HELPING TO HEAL:

A Training on Mental Health Response to Terrorism

Manual

Prepared by:
Community Resilience Project of Northern Virginia

Commonwealth of Virginia Department of Mental Health,
Mental Retardation and Substance Abuse Services

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Community Resilience Project of Northern Virginia
COMING TOGETHER TO HEAL

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PREFACE

Since September 2001, Northern Virginians have experienced not only the 9/11 attacks, but also the anthrax attacks, the sniper attacks, the continued terror alerts, and the war on terrorism. Two years later, thousands of otherwise healthy people in Northern Virginia are still afraid, anxious, or sad and are experiencing fatigue, having difficulty concentrating, or having problems sleeping. These persistent reactions show how long lasting the impact of terrorism can be. They also show the ongoing need for mental health professionals and paraprofessionals to help people recognize and cope with these reactions.

As a Disaster Mental Health Coordinator for the last 16 years, I have directed the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services' response to a wide variety of disasters, including the 9/11 terrorist attacks. I also have had the honor of serving as the Director of the Community Resilience Project of Northern Virginia. This project was established through a Federal Emergency Management Agency (FEMA) grant to help people in Northern Virginia recognize and cope with their reactions to 9/11 and the terrorist events since then.

Different from natural disasters, terrorist attacks are manmade, with the intent to cause harm, instill fear, and undermine our sense of security. How disaster mental health workers prepare before an attack and the steps we take immediately after are critical in helping individuals and communities cope with the terrible impact these events have. This training provides information and suggestions based on our unique experiences to help mental health professionals and paraprofessionals prepare now, and to help them know what to do in the early phases of the response.

This training includes a manual, a field guide, and a CD-ROM. The CD-ROM includes checklists, Web links, expert interviews, and role-plays. The training represents what we know and have experienced until now. Mental health response to terrorism is evolving. Therefore, mental health workers are encouraged to continue to learn about and keep up to date on the latest interventions and strategies to help individuals and communities prepare for and cope with terrorism.

The psychological casualties of terrorism far outnumber physical casualties. Preparing now—with plans, training, and coordination—to deal with the psychological impact of another terrorist attack is essential. This training can be a valuable tool for mental health workers as they encounter the challenges and rewards of nurturing and celebrating the resilience of those who have survived the unthinkable.

Bill Armistead
Assistant Director, Office of Planning
Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services
Project Director, Community Resilience Project

INTRODUCTION

Domestic and international terrorism are not new to the United States. Examples of other terrorist events that have captured the nation's attention include:

- February 26, 1993. A massive explosion at New York's World Trade Center resulted in six casualties and more than 1,000 people injured.

- April 15, 1995. The Alfred P. Murrah Building bombing occurred in Oklahoma City. At the time, it was the deadliest terrorist event on American soil, resulting in 168 deaths, including 19 children. In addition, 853 people were injured, 30 children were orphaned, 219 children lost a parent, and 400 individuals were left homeless. The entire nation was deeply touched by this tragedy and outraged that an American had committed this act of terrorism. America's Heartland fell victim to one of its own; America struggled to comprehend the incomprehensible. The State of Oklahoma received funding from Federal Emergency Management Agency (FEMA) and the Office for Victims of Crime to administer Project Heartland, a crisis-counseling program for victims of the bombing.

- July 1996. A pipe-bombing disrupted the Atlanta Olympics.

- September 11, 2001 (9/11). Terrorists perpetrated the most heinous attack on American soil ever experienced in the history of the United States. The horrifying attack on and collapse of the World Trade Center resulted in thousands of deaths. In Northern Virginia, the Pentagon sustained major damage with three of its five rings penetrated. The human toll involved the death of 189 individuals, including 64 persons onboard American Airlines flight 77. Consequently, the Commonwealths of Virginia and Massachusetts, the states of New Jersey, Connecticut, and New York, and the District of Columbia received funding from FEMA to operate crisis-counseling projects.

The Community Resilience Project (CRP) of Northern Virginia was established through a FEMA grant to provide crisis counseling services through January 2004. It was administered through the Commonwealth of Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services, and by the Community Services Boards of the City of Alexandria and the counties of Arlington, Fairfax, and Loudoun. This training is based on the experiences of the CRP disaster mental health workers.

We often heard people say that the Community Resilience Project was evidence that the federal, state, and local governments cared about the emotional and practical needs of the people in our community. The presence and work of the outreach workers helped the community feel supported and cared for so that individually they could be strong.

Deborah Warren, L.C.S.W., D.C.S.W.
Project Director, Alexandria
Community Resilience Project

Since 9/11, the residents of Northern Virginia have experienced cumulative trauma as a result of events that are still unfolding. The terrorist disaster that began 9/11 cannot be characterized as a single event. Rather, it has encompassed a series of terrorist threats and actions designed to provoke widespread fear and anxiety among

citizens in Virginia and across the nation. As a result, the CRP not only responded to the attack on the Pentagon. Its counselors have responded to the ongoing series of events since 9/11, including the anthrax attacks, various hate crimes, the sniper attacks, continued threats of terrorism, and the war on terrorism.

As the fear of bioterrorism in the form of smallpox was looming, a new threat in the form of the deadly virus, Severe Acute Respiratory Syndrome (SARS), invaded our area. There was serious concern about the virus affecting people in Northern Virginia as persons traveling from or through the infected countries flew into and out of Dulles International and Reagan National, Northern Virginia's two major airports. The continued media coverage of these events kept them very fresh in Northern Virginians' minds, which further instilled fear and concern that the next event was right around the corner.

The ongoing threat from current and future terrorist activities has led many otherwise healthy people to experience sustained anxiety manifested as fear, anger, and irritability. The people of the Commonwealth of Virginia have been exposed to a series of traumatic events that have left many of them experiencing grief, terror of death, disruption of daily life, anxiety, helplessness, uncertainty, and anger.

Table 1 illustrates the range of traumatic events that have affected Northern Virginia since 9/11.

Underneath there was a lot of pain, a lot of frustration, a lot fear, a lot of anxiety… There was almost a psychological fatigue that set in… There was really no time to heal… There were so many things all at once: 911, anthrax, the sniper, the war, the high alert… Our phones really started ringing, and people started coming in. When we started talking to them, it wasn't just about those events… it was this long term "When is this going to end?" and "When are we going get a break so we can heal?" type of thing. So that was one of the things that was so hard to deal with.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

Table 1. Community Traumatic Events

Event	2001				2002					2003		
	Sep	Oct	Nov	Dec	Jan	Mar	Sep	Oct	Dec	Feb	Mar	Apr
9/11 Attack on Pentagon												
Anthrax mail attacks												
War on Terrorism												
Terror Alert System												
Terror Alert raised												
Terror Alert lowered												
Anniversary of 9/11												
Sniper attacks												
Smallpox inoculations												
SARS												

Terrorism

> *The basic law of terrorism is that even the smallest threat can ripple out to touch people a thousand miles away. The basic goal of psychological interventions is to understand the traumatic impact of terrorism and to use that understanding to minimize and contain the ripple effect within the individual, community, and our nation.*
>
> ——American Psychological Association Report on the Oklahoma City Bombing, 1997

What makes an act of terrorism so very different from a natural disaster is the intent behind it—to harm, kill, and scare defenseless people to deliver a message for political, religious, or sociocultural purposes. Coping with these acts can set off a chain of psychological events culminating in feelings of fear, anger, helplessness, vulnerability, and grief.

Terrorism has been defined, as follows:

> *An activity that involves a violent act or an act of dangerousness to human life that is in violation of the criminal laws of the United States, or of any State … and that appears to be intended to intimidate or coerce a civilian population … or to influence the policy of government by assassination or kidnapping.*
>
> ——Department of Justice [18 U.S.C. 3077]

Terrorism is differentiated in terms of domestic and international terrorism.:

> *Domestic terrorism involves groups or individuals whose terrorist activities are directed at elements of our government or population without foreign direction.*
>
> ——Federal Bureau of Investigation
> www.fbi.gov

> *International terrorism involves groups or individuals whose terrorist activities are foreign-based and/or directed by countries or groups outside the United States or whose activities transcend national boundaries.*
>
> ——Central Intelligence Agency
> www.cia.gov

Both domestic and international terrorism affect the whole community and its impact can have long-term and widespread effects. Terrorism can have physical, emotional, and financial impacts, which can be exacerbated by existing factors or conditions. Therefore, this training is for the benefit of those who may be deployed to provide psychological first aid at a terrorist disaster site, as well as for any professional or paraprofessional who may provide mental health services to individuals affected by terrorism, including direct and indirect survivors.

The Role of Disaster Mental Health Workers

The role of the disaster mental health worker as well as the location and types of services that will be offered after a terrorism event are defined by the type and impact of the event. Terrorism may move some disaster mental health workers to the role of a first responder. The mental health response to terrorism is community-based. Services may be provided in a family service center where family members find out the status of their loved ones, at the site, and at various locations throughout the community. A disaster mental health worker may be asked to provide basic services, such as bringing clean water and clothing to the first responders and survivors at the site or in a family service center. During the immediate phase, providing support is often what is most needed. A disaster mental health worker also may need to do rapid assessments, provide immediate counseling services, and outreach, or even participate in death notifications.

The experience, training, and qualities that disaster mental health workers possess make them uniquely qualified to provide counseling and supportive services immediately after terrorist events. These qualities include flexibility, sensitivity, the ability to set and respect boundaries, and a commitment to helping people.

Regardless of the event or of the role of the disaster mental health worker, one thing that will be important is helping individuals and communities heal by building their resilience skills—their ability to recover from tragedy.

About This Training

This manual is part of a larger training kit that was developed to better prepare mental health professionals and paraprofessionals about the early phases of the response to a terrorist or mass trauma event. While much of the information may be applicable both to a terrorist event and to a natural disaster, this training kit is intended for use in preparation and response to an act of terrorism. It provides training and information on:

- How to prepare for terrorism (Module 1)
- How terrorism affects individuals and communities and what to expect at the site of a terrorist attack (Module 2)
- What services and interventions may be appropriate during the initial response to a terrorist event (Module 3)
- How to understand and respond to the mental health needs of different populations (Module 4)
- How to communicate effectively during emergency and crisis situations (Module 5)
- How to care for the mental health and safety of disaster mental health workers (Module 6)
- How to manage an effective mental health program by planning and preparing staff (Module 7)

- How paraprofessionals can use their strengths to provide a range of practical services and basic psychological support (Module 8)

The information is presented in a modular format. While each module is a stand-alone training piece, disaster mental health workers are encouraged to experience the modules in the order in which they appear because the information in each module builds on previous modules. (The last two modules were designed for specific audiences, e.g., Module 7 trains managers and supervisors; Module 8 trains mental health paraprofessionals).

Large-scale mental health or crisis counseling projects for terrorism have only recently been funded in the United States. Because little information has been available about mental health related to terrorist disasters, CRP staff used information from mental health data and resources related to *natural* disasters, and tailored it to meet the often very different needs of individuals and communities affected by a terrorism event. Much of the information presented in this manual is adapted from existing mental health publications related to natural disasters, and reflects ways in which Community Resilience Project staff adapted that existing information for the mental health response to 9/11.

One of the most important things that came out of 9/11 is the government's very public and then well-resourced commitment to doing planning so that [we] would not have to go through the same kind of scenario should there be another incident that would affect [us] similarly.

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

The field of mental health response to terrorism is evolving quickly as many federal and state agencies, and private organizations are beginning to collect and analyze information about the psychological impact of terrorism. As more data becomes available about what to expect and the best ways to help people heal, disaster mental health workers will be able to expand their knowledge about terrorism. *Helping to Heal: A Training on Mental Health Response to Terrorism* is among the first of its kind to share information, knowledge, and experiences of those who have provided mental health responses to individuals and communities affected by terrorism. The CRP staff hopes that disaster mental health workers will find this training useful and encourages them to continue learning as new information becomes available.

Definitions of Frequently Used Terms

Mental health professional—A social worker, psychologist, psychiatrist, or other licensed or credentialed mental health provider. A mental health professional may work in a private practice or with a county/city government agency.

Mental health paraprofessional—An individual who alleviates the pain and distress of affected groups and individuals during a response effort, but is not a licensed or credentialed mental health provider.

Disaster mental health worker—Either a mental health professional or paraprofessional who provides disaster mental health services.

Victim—An individual who has experienced the immediate impact of a terrorist event.

Survivor—An individual who has experienced the impact of a terrorist event either indirectly or directly.

We are, as a people, trying to determine what the new "normal" is. Will we keep on experiencing the things that we have experienced? Will we ever get our equilibrium back? And, you know, I think we will. I don't know exactly what it will be like, but I think we will. I think we must face the future eager to take on what life brings us and really face the future with the "glass half full" mentality. If you look back at the struggles that we have endured over the last 50 years in our country's history, we've come through some horrible, bad times before…And we will come through these times, and we will find what the new "normal" is for us as a people.

Donna M. Foster, M.S.W.
Project Director, Fairfax County
Community Resilience Project

MODULE 1: HOW TO PREPARE

This module is intended to provide the information and planning tools necessary to achieve personal, professional, and organizational preparedness prior to a terrorist attack. It also provides information on the roles and responsibilities of the disaster mental health worker at the site of a terrorist attack, based on the experiences of those who provided services during the immediate aftermath of 9/11. It concludes with information on navigating the complex coordination and roles of the various government agencies that may be present at the attack site.

After completing this module, the disaster mental health worker will be able to:

- Plan and prepare personally, professionally, and organizationally for a disaster
- Identify approaches to increasing access to a community and to a terrorist site
- Recognize the many forms that his or her role may take during a response to a terrorist event
- Better coordinate services with key emergency support agencies

Preparedness Planning

Preparedness can be grouped into three general categories: personal, professional, and organizational. Although distinct, these three categories are interrelated and equally important with respect to preparing oneself to respond to a terrorist attack. The following sections provide a large amount of information and guidance on how to achieve each level of preparedness. It is important to note that preparedness planning is an ongoing process and each individual should proceed at his or her own pace. In addition, the following guidelines are intended for a broad audience, and may need to be adapted to an individual's lifestyle and personal needs. Therefore, not every individual will find it necessary to follow each of the steps in these guidelines.

> *There's so much that needs to be done, I think, to prepare for another attack. As far as mental health professionals, I think they really do need to have more education and training. First of all, on how to deal with clients who are dealing with mass tragedy, and there is all kinds of training available…Secondly, I truly think mental health professionals need…a more community-based outlook, to realize [the need for] and to get some training in some public health community-based outreach program…In this type of situation, you really need to get out into the community. You can't wait for them to come to you.*
>
> June Eddinger
> Project Director, Loudoun County
> Community Resilience Project

Personal Preparedness

When an emergency occurs, it is both natural and healthy to be concerned about the safety and well-being of our loved ones. Without that assurance, work can become secondary. Disaster mental health workers are likely to be called on to fill any number of roles and may need to work

extended hours for several days at a time. Therefore, it is important that each disaster mental health worker develop a personal emergency preparedness plan that includes:

- How to make contact with family and other loved ones during an emergency
- What each member of the family can do to help ensure his or her own safety and the safety of others

Below are some recommended steps for developing a personal emergency preparedness plan.

- Learn the immediate community's warning signals and notification systems. Each community has its own system, and warnings may range from sirens over loud speakers to messages broadcast on local radio and TV stations.
- If children are in the home, establish a plan for their care in the event that parents or other caregivers are called away to help.
- If there are older or disabled family members, make arrangements for taking care of their special needs.
- Make sure that the places where the family spends much of its time—such as work, school, and day care—all have disaster plans, and that practice drills are conducted on a regular basis.
- If there are pets in the home, establish a plan for their care. In addition, inquire about the availability of animal care after a disaster. Many shelters do not admit animals due to health regulations.

Family Emergency Preparedness Plan

Without knowing what kind of event will occur and what kind of resources will be needed, personal preparedness may seem like an impossible task. That is why it is so important for disaster mental health workers to develop and put plans into place *now*, before an event.

Planning is not that difficult, and it is very important. Disaster mental health workers can use the following checklist as a guide for the family's emergency preparedness planning efforts.

- ❑ **Meet to discuss why and how to prepare for a disaster.**
- ❑ **Discuss each type of disaster that could affect the family and how to respond.**
- ❑ **Make a map of the house and identify two escape routes from each room.**
- ❑ **Identify two meeting places, one inside the neighborhood and one outside, in case the family is separated and cannot return home.** Make sure all family members have the addresses and phone numbers of these meeting places and keep this information on their person at all times.

- ❑ **Identify an out-of-state family member or friend to be the family contact.** Depending on where family members are at the time of the attack, it may not be possible to reunite. Because it may be easier to make a long distance call than a local one, however, an out-of-state family contact can help coordinate communication among loved ones during a crisis. Make sure that all family members have the phone number of the contact person with them at all times, and, in the event of an emergency, know to call this person to tell them their location. Make sure to inform that person that family members will be calling him or her in case of an emergency.

- ❑ **Post a list of emergency phone numbers by each telephone in the house.** Include numbers for the fire department, police, an ambulance service, the family contact, family pagers and cell phones, neighbors, workplace contacts, schools and day care centers, and other important contacts. Ask family members to keep a copy of this list in their wallets or purses.

- ❑ **Identify backup communications systems.** On 9/11, telephone and other communications lines were jammed. Recognize that phone lines may be down, and other communications systems may be more appropriate, such as e-mail, pagers, personal digital assistants, etc.

- ❑ **Instruct children about how to make a long distance call.** This is particularly important if long distance numbers are included on the family's emergency contact list.

- ❑ **Ensure at least two ways of contacting each other during an emergency.** Since phone lines may be down or jammed, consider e-mail or text messaging as alternate modes of communication.

- ❑ **Teach children how and when to call 9-1-1 for help.** If the family resides in a rural area that does not use 9-1-1, make sure children know how to dial the local emergency medical service.

- ❑ **Show each family member how and when to turn off the utilities (e.g., water, gas, electricity) at the main switch.** Although this may seem extreme, remember that an adult may not be home at the time of the emergency, and children may need to protect themselves from a gas leak or other hazard.

- ❑ **Show each family member where the fire extinguishers are kept and how to use them in an emergency.**

- ❑ **Install and regularly test smoke detectors on each level of the house, especially near the bedrooms.** To ensure that detectors are in working order and that batteries are charged, conduct a test of all smoke detectors in the house on the first of every month.

- ❑ **Take a first aid and CPR class.**

- ❑ **Store family records in a water- and fire-proof safe.** Include birth and marriage certificates, social security cards, insurance policies, bank records, stock and bond certificates, wills,

deeds or leases, and other important documents. Since the home may be damaged, make a list of all important household possessions for insurance purposes, including model and serial numbers. Consider taking photos or videotaping belongings as well. Store another copy of the records in a safe-deposit box or another secure location away from home.

- ❑ **Stock and regularly maintain a family preparedness kit.** Make sure to replace stored water every three months and food every six months (see checklist below for recommended contents).

Posting the family emergency preparedness plan on the refrigerator at home and conducting regular practice drills with family members will help to increase their comfort level and confidence in their ability to respond. Having a different member of the family "manage" the drill each time can ensure that everyone is comfortable and can make it a family activity. It is a good idea for family members to carry some sort of identification on their person at all times.

Family Preparedness Kit

Disaster mental health workers may consider having a large duffle bag or plastic container to hold many of the items for their preparedness kits to facilitate access and transport. As disaster mental health workers may be out in the field for long periods, they may want to keep another less comprehensive preparedness kit for personal use in a backpack in the car or office. Below are suggestions for items to include in a family preparedness kit.

The Basics

- Water, at least one gallon per person per day, for three to seven days
- Foods that do not require refrigeration or cooking, such as peanut butter and granola bars, at least enough for three to seven days
- At least one flashlight with plenty of extra batteries
- A battery-powered radio with extra batteries
- A first aid kit, including a supply of all prescription medications currently taken by family members in their original bottles, plus copies of the prescriptions and any other important medical information, such as physicians' contact information
- Eyeglasses, with a copy of the prescription
- Plastic garbage bags, ties, and toilet paper for personal sanitation
- Feminine supplies
- A plastic bucket with tight lid
- Moist hand wipes
- Cash, including coins, as ATMs and banks may not be open or available

- A map of the area, to identify evacuation routes and locate shelters
- Special items that small children and the elderly might require
- Toys, books, and games
- Nonperishable food for pets

Clothing and Bedding

- At least one change of clothes, including shoes, for each family member (both warm and cold weather clothes if the area is affected by the seasons)
- Pillows and either sleeping bags or warm blankets for each family member

Tools

- A first aid book
- A signal flare and compass
- Mess kits or plastic utensils and paper cups and plates
- A nonelectric can opener
- A utility knife
- A small fire extinguisher
- Matches in a waterproof container
- Paper towels
- Aluminum foil and plastic storage containers
- Paper and pencils or pens
- Pliers and a shut-off wrench, to turn off household gas and water (if necessary)
- Regular household bleach and a medicine dropper, to purify water in an emergency (Use 16 drops per gallon of water.)
- Plastic sheeting and duct tape
- A tube tent (i.e., a simple survival tent)

Professional Preparedness

While some disaster mental health workers will be deployed to the site of a terrorist attack, it is likely that others may need to stay behind to care for existing patients. Therefore, in addition to developing personal preparedness plans, policies and procedures will need to be established to ensure that patients receiving regular mental health services continue to be provided for in the event of an emergency. Although managers ultimately will need to make the decision about which staff members will be deployed, all staff members should be familiar with management's emergency deployment plans before a terrorist attack so that they are comfortable with management's expectations of them. In addition, this advance preparation will allow staff to seek out additional training, if necessary, to complement their current skill set and better prepare them to assume their assigned responsibilities during an emergency.

Disaster mental health workers should have personal preparedness kits that they keep in their cars or offices in case they are stuck at work in an emergency or are deployed directly from work to a disaster site. Whether this kit is stored in one's car or office depends on the individual, as does the contents of the work kit. A work kit does not need to be as extensive as the family kit, but it still needs to have the basics (e.g., water, medicine, flashlights).

Organizational Preparedness

This section discusses organizational preparedness that cuts across site-specific concerns such as staffing a response effort. Organizational preparedness plans incorporate strategies to increase access to disaster sites and to affected communities. In addition, these strategies may also increase the likelihood that the disaster mental health worker will be invited to be part of an interdisciplinary response team. The importance of laying the foundation for gaining access during a disaster is emphasized in the following sections.

In the initial days, there was tremendous pressure to gather information. The mechanisms we used to accomplish this included the Internet, telephone calls, meetings, or someone being able to network and connect us with someone else who might have had a fill-in piece of information. We were truly in touch with every relevant agency in the county to help with the grant, including the demographers and the map people. It is because we didn't have those collaborative working relationships already established that we were frantic. It was not easy. In fact, it was truly a challenge but, I am happy to say, a challenge we were able to overcome. Perhaps the most valuable lesson learned was: The more you can be in the network of Disaster Mental Health prior to a disaster, the better off you'll be.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

Ensuring Access to the Disaster Site

In the chaos and confusion of 9/11, many first responders who were not in fire and police uniforms or were without appropriate identification found it difficult to access the disaster sites. This was true for health department and volunteer emergency medical service (EMS) personnel, as well as mental health workers from the local mental health authority. (In Virginia the mental health authorities are Community Services Boards.)

Community Services Boards and other organizations that will be responding to terrorist incidents can take steps to ensure that staff can gain access to disaster sites by:

- Providing them with the identification tools necessary to increase their recognition within the community
- Fostering relationships with other organizations they will be working or coordinating with at the disaster site

It is advisable for disaster mental health workers always to carry some form of identification, such as a driver's license or other photo ID. However, if the identification does not identify the person as a disaster mental health worker to the "gatekeepers" of a site, it will be insufficient for providing access to the site. Methods that may increase access can take the form of uniforms, promotional materials, or sponsorship of community outreach events before an event even occurs. Regardless of the tactic, its purpose will be to increase staff recognition and, thus, access. Disaster mental health workers need to be sure that the identification they present—whether it be a letter of introduction from an employer, a special badge, a T-shirt, or a baseball cap with insignia—will be recognized by getting to know first responders now, before an event.

One of the most important relationships that needs to be pre-established is the relationship with the State Emergency Mental Health Coordinator…For us, he was a wealth of information, a wealth of support. There are things that have to be done very, very quickly in a disaster if an agency is to receive a FEMA grant, which is how our Community Resilience Project was funded. A second, most important lesson learned in our county was that it is crucial to have a working relationship with the Red Cross…For mental health, in terrorist-related types of disasters, the State Disaster Mental Health Coordinator, the local Red Cross chapter, and the Employee Assistance group within your particular organization are probably the three pre-established relationships that are most critical in the provision of mental health services.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

It is also important that they develop a relationship with local fire, police, American Red Cross, and other EMS agency personnel before a crisis to increase the likelihood of their gaining access to a site immediately after a terrorist attack.

Conducting Community Outreach Before an Event

One component of emergency preparation includes conducting community outreach not only with local emergency support agencies but also within the community itself. Knowing and being known within the community will increase access to the site of the event, improve access to the different populations that will likely be represented at the site, and allow for better provision of care. Disaster mental health workers will find the steps below helpful to developing a pre-crisis community outreach plan.

One of the key lessons coming out of our work in communities is that, from a preparedness perspective, we need to be building relationships in those communities. You can't create relationships while disaster strikes, and it's difficult to go into impacted communities directly after a disaster if you have no relationships from which to work. We've learned that social connection is very important, both in terms of mitigating the post-traumatic distress and as a resource for folks to help prevent some of the more serious psychological consequences of a traumatic incident. If we do not have relationships that allow us to work within those communities' own social connections and within their own infrastructure, we're not in the places we need to be at the time when we need to be there.

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

- Develop a presence with local government emergency planning committees.
- Establish relationships with staff at local community- and faith-based organizations.
- Be familiar with the key population centers of the community, the languages spoken within it, and the language resources that are available.
- Create a list of places in the community where people naturally congregate, such as grocery stores, libraries, community centers, malls, etc. These sites can serve as outreach posts following a disaster.
- Inquire about and learn the community's established escape routes.
- Identify other resources in the region that may be useful during an emergency (see example on next page).
- Develop a phone list of key numbers, and update it regularly (see example on next page).

In addition, disaster mental health workers will want to explore the resources within their neighborhoods or workplaces that might increase access or job performance in the event of an emergency. For example, a neighbor's four-wheel-drive vehicle could come in quite handy to access the site of a terrorist attack if the attack occurred just after a heavy snowstorm.

Table 1–1. Example of a List of Regional Resources and Local Phone Numbers from Arlington County Disaster/Emergency Resources

Below is an example resource list provided by Arlington County. Use this to create a resource list for your area. *(Please note that these telephone numbers are current as of 2003, but may be changed in the future.)*

City/County/Regional Resources

Arlington County Department of Human Services, Child and Family Services
(703) 228-1550

Arlington County Non-Emergency Police Number
(703) 558-2222

Arlington County Information and Referral Service
(703) 228-3000

Arlington County Web site
http://www.co.arlington.va.us

City of Falls Church Department of Housing and Human Services
(703) 248-5005

City of Manassas Department of Social Services
(703) 361-8277

Fairfax County Human Services Coordinated Services Planning
(703) 222-0880

Fairfax City Department of Human Services
(703) 385-7894

Information and Referral Line for the Arlington County Department of Human Services
(703) 228-1300 or (703) 228-1350

Loudoun County Department of Social Services Information and Referral Services
(703) 771-5400

Northern Virginia Regional Commission's Quick Guide
http://www.novaregion.org/qgonline.htm

Prince William County Department of Social Services
(703) 792-7500 or (703) 792-4300

Mental Health Services

Adult Mental Health Services
(703) 228-5150

Arlington Emergency Mental Health Services
(703) 228-5160 or (703) 228-4256

Services for Specific Populations

Hispanic Committee of Virginia, Arlington
(703) 243-3033

Hispanic Committee of Virginia, Falls Church
(703) 671-5666

Hispanics Against Child Abuse and Neglect (HACAN) and Strengthening Families Parenting Program
(703) 208-1550

Social Service Organizations

Administration Office for Catholic Charities
(703) 841-3830

American Red Cross Arlington
(703) 527-3010

American Red Cross Alexandria
(703) 549-8300

American Red Cross National Headquarters Voice Mail System
(703) 573-7681

Arlington Employment Center
(703) 228-1400

Christ House Soup Kitchen and Emergency Assistance
(703) 548-4227

Crisis Assistance Bureau
(703) 228-1300 or (703) 228-1350; Fax (703) 228-1013

First Call for Help, United Way of Central Maryland
(800) 492-0618

Haven of Northern Virginia
(703) 941-7000

Information and Referral Services
(800) 230-6977

Salvation Army Arlington
(703) 979-3380

Salvation Army Family Services Office of Alexandria
(703) 548-0579

Office of the Salvation Army
(703) 385-8700

Virginia Department of Social Services Child Abuse and Neglect Hotline
(703) 228-1500

Virginia Employment Commission
(703) 813-1332

Substance Abuse Services

Alcoholics Anonymous (Northern Virginia Intergroup)
(703) 876-6166

Arlington County Substance Abuse Services
(703) 228-4900

Northern Virginia Help Line of Narcotics Anonymous
(703) 532-1255

Understanding Roles and Responsibilities

To the outsider, the scene of a terrorist attack involving mass casualties may appear to be confusing and chaotic. Due to the urgency required to rescue lives and secure the area, the response to an act of terrorism is intense and fast-paced. In addition, a large number of federal, state, and local organizations respond to such large-scale disasters, requiring that services be coordinated on many levels. Being clear about the roles and responsibilities of a disaster mental health worker before a disaster may help these workers acclimate and assist survivors more quickly, as well as avoid inadvertently adding to the confusion.

Lessons learned from disaster mental health workers who provided support at the World Trade Center and the Pentagon offer insight into what may be expected of a disaster mental health worker after a terrorist attack, as well as an indication of the services they may be asked to provide. Due to the magnitude of the disaster, many of the disaster mental health workers who provided support on 9/11 said that very often their support role came in the form of passing out socks and other supplies to recovery workers, or serving a survivor coffee and chatting with him or her for a few moments. They explained that, while these acts may not seem like mental health interventions, they were the kind of support that was needed at the time, and it was those initial contacts that led these victims to seek support from disaster mental health workers in the days, weeks, and months that followed.

> *Disaster mental health is somewhat different than what we typically do in a mental health treatment setting. We need to support people, help them feel nurtured, and soothe them and comfort them in times after disaster. Sometimes this involves acting in non-traditional roles, such as helping people at a disaster scene with some concrete needs like getting a cup of coffee or a blanket. The emphasis is on "being with" the disaster victim or disaster worker, allowing them to talk, and listening with a fully engaged heart and mind.*
>
> Donna M. Foster, M.S.W.
> Project Director, Fairfax County
> Community Resilience Project

Many of those who provided services to survivors in Virginia, New York, and other areas affected by 9/11 have shared that their traditional training did not prepare them for the kind of support often required by the survivors of 9/11. Rather, they actively resisted the urge to pathologize a survivor and often found that the simplest form of support was well received by family members and rescue workers. That support role took the following forms:

- Just listening, "being there," or "hanging out"
- Introducing and being available to the chaplain on site, if one was available (for referrals)
- Providing general support and comfort to anyone affected by the disaster, including those who were both directly and indirectly affected, as well as EMS and other recovery workers

- Providing consultation to other medical and recovery personnel on how to minimize further distress
- Providing aid, at the direction of emergency workers, to a survivor whose psychological state might inhibit efforts to rescue him or her
- Offering support to the bereaved, either at the site, at a shelter, or at the morgue
- Providing information about and referral to community resources
- Getting someone a cup of coffee

In those initial hours, we did a lot of telephone crisis-call work, providing information. We are also right next door to one of the local hospitals that received some of the victims, and so we participated with the hospital in being available to talk with concerned family members, along with Crisis Link—our contracted suicide hotline service. Crisis Link also moved a temporary phone bank into the hospital. And over a 3-day period, they took over 6,000 calls from people all over the country who were concerned about loved ones who worked at the Pentagon. So, in those early days, our services probably fell in the categories of supporting the first responders, whether it was those working at the site or those providing services at the hospital, and just attempting to help our own community at large…to maintain a low level of anxiety.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

Identifying the Chain of Command

Identifying and reporting to whoever is in charge will be critical to the disaster mental health worker's ability to access the site and to provide support to those in need. There will likely be a number of different first responder agencies and organizations at the disaster site, which can make it difficult to determine the chain of command and to whom to report at the site. In addition, certain mutual aid organizations, e.g., local chapters of the American Red Cross, may have different operating procedures in different regions, making the community outreach plan mentioned earlier all the more important. Module 2 provides more information to help the disaster mental health worker navigate through what may be unclear waters. However, reviewing state and local emergency plans before a disaster will be helpful as well. (It is important to note that chain of command is different from incident command. For more information on incident command, see http://www.fema.gov/rrr/conplan/conpln4b.shtm.)

Summary

The importance of advanced planning and preparation cannot be emphasized enough. While there is no way to anticipate what type of event may occur or the magnitude of the disaster mental health worker's involvement, the development and implementation of personal, professional, and organizational preparedness plans will increase the disaster mental health worker's access to the site and to the communities affected, as well as the quality of the services provided. In addition, familiarity with each worker's own roles and responsibilities, as well as with the likely chain of command at the scene of the disaster, will result in a more focused and successful effort for both the disaster mental health worker and those served.

Additional Resources

Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, http://www.dmhmrsas.state.va.us.

Virginia Department of Health, Emergency Preparedness, and Response, http://www.vdh.state.va.us/bt/index.html.

Virginia Department of Emergency Management, http://www.vaemergency.com.

MODULE 2: WHEN TERRORISM HAPPENS

With preparedness planning completed, this module moves on to what a disaster mental health worker can expect at the site of a terrorist attack. It explains how terrorism impacts those who experience it directly or indirectly. It describes the "ripple effect" of terrorism, as its intensity subtly spreads and impacts the community's mental health, culture, and economy. This module also describes the phases of recovery from terrorism, the importance of conducting rapid needs assessments, who may be expected to support a response to terrorism, and ways to determine who is in charge onsite. It concludes with a discussion of the roles that a disaster mental health worker may be asked to assume on the site, stories from the field, and guidance from members of the Community Resilience Project (CRP) staff on recognizing one's own strengths and limitations prior to volunteering for onsite duty.

After completing this module, the disaster mental health worker will be able to:

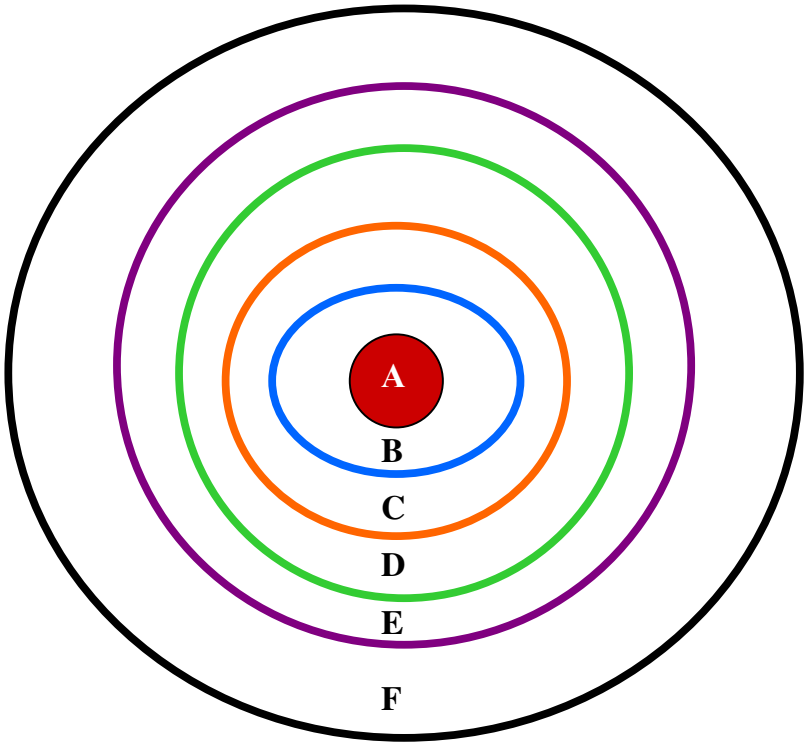
- Understand the "ripple effect" of terrorism on the mental health of individuals and communities
- Recognize the impact of terrorism on a community's culture and economy
- Identify and recognize the phases of recovery from terrorism
- Conduct an onsite assessment
- Identify the roles and responsibilities of the key response agencies at the local, state, and federal levels during a response to terrorism
- Identify the role of the disaster mental health worker onsite

Impact: Recognizing the Ripple Effect

The physical impact of a terrorist event involving mass trauma and casualties is concrete and visible. The psychological victimization, however, is much more subtle in nature, sending waves of shock and distress throughout the community, the state, and often the nation. A population exposure model is used to depict the widespread impact that mass violence has on the various victims, families, responders, and community groups that may be affected. This model,[1] illustrates how the collective social, political, environmental, and cultural impacts of a large-scale community disaster interact with individual reactions and coping strategies. Employing a public health approach to understanding the effects of terrorism, the model provides the disaster mental health worker with a macro-view of the enormity of its impact. Beginning with the reactions of those most directly impacted by the event, the model portrays the "ripple effect" of terrorism; that is, how terrorism echoes to leave nearly everyone affected.

[1]DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Figure 2–1. Population Exposure Model[2]



Key:

A: Seriously injured victims; bereaved family members, loved ones, close friends

B: Victims with high exposure to trauma; victims evacuated from the disaster

C: Bereaved extended family members and friends; rescue and recovery workers with prolonged exposure; medical examiner's office staff; service providers directly involved with death notification and bereaved families

D: People who lost homes, jobs, pets, valued possessions; mental health providers; clergy, chaplains, spiritual leaders; emergency health care providers; school personnel involved with survivors; families of victims; media personnel

E: Government officials; groups that identify with the target victim group; businesses with financial impacts

F: Community at large

[2] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The Population Exposure Model is a useful tool for beginning to assess and understand the needs of the community. There are groups of victims, however, that are not identified or integrated into the model. For example, a significant number of people who experienced a prior trauma, such as a violent crime, terrorism, or war, and were in Northern Virginia on 9/11 demonstrated psychological symptoms from traumatic exposure. Individuals did not have to work at or be located near the Pentagon on 9/11 to be exposed to the trauma and develop trauma-related symptoms. For example, the immigrant populations experienced a growing sense of isolation and backlash from the mainstream community. Members of the Muslim community experienced antagonism and were victims of hate crimes. It is important to look beyond the groups listed in the model and identify all people who are impacted by a terrorist incident and the aftermath.

What surprised me the most was the elongated effect of things, in that, of course, there is the immediate aftermath of 9/11 where people, those directly affected, the victims, the ones that were injured, and of course the families, are affected, but also the community at large. And then, as time marched on, there were more distinctions within the community at large, as to subgroups of the population that were affected, such as immigrants and various ethnicities in our community.

Donna M. Foster, M.S.W.
Project Director, Fairfax County
Community Resilience Project

Individual Reactions to Stress

Stress reactions often surface after people have grappled with their immediate situations. The intensity of the reaction is determined by the magnitude of these life concerns. It also may be influenced by certain characteristics of a terrorist event, such as:

- Threat to life and limb
- Severe physical harm or injury
- Receipt of intentional injury/harm
- Exposure to the grotesque
- Violent/sudden loss of a loved one
- Witnessing or learning of violence toward a loved one
- Learning of exposure to a noxious agent
- Intentional death or harm caused by others

Survivors may be affected in less direct ways, as well. Often terrorist attacks paralyze entire communities and business industries, impacting the financial stability of their residents. Following 9/11, for example, tourism in Northern Virginia and the DC metropolitan area came to a complete halt. The airports were closed, conferences were canceled, and school trips were rescheduled. People working in the tourism, hospitality, and other related industries were affected financially. Once the airports reopened, the travel business resumed, but some

businesses continued to be affected because of the race or ethnicity of the owners or workers. Consider this scenario . . .

> *A taxi driver is relieved to be able to resume his airport route, which before 9/11 generated the most revenue. But he quickly learns that because of his Middle Eastern descent, passengers are refusing to get into his cab. And those who do are sometimes hostile and threaten violence against him and "his people."*

This scenario points out the complexity and nuance of terrorism's impact and the importance of being sensitive to the many ways that individuals may be affected.

Terrorism can affect entire populations. This may be particularly true of immigrant groups, especially those with large numbers of refugees. Module 4 presents an in-depth look at the population-specific vulnerabilities that may influence a community's reaction.

Phases of Recovery

Much of what has been written about providing disaster mental health services is related to natural disasters. Therefore, the model for providing services and trying to understand the phases people have gone through in the days, weeks, and months following a terrorist attack has been based on crisis counseling for natural disasters (see Table 2–1).

Table 2–1. Phases of Recovery from Natural Disasters

Impact Phase	• Initial shock of the event • Reactions include confusion, disbelief, and worry
Heroic Phase	• High activity concentrated on rescue efforts and evacuation • Community cohesion as people come together to donate goods and services • Temporary suspension of community tensions (e.g., between different racial/ethnic groups) • Anxiety intensified if family members are separated
Honeymoon Phase	• High level of optimism as the community works together • Quality of interaction between relief workers and survivors crucial to perceptions of the total relief effort as well as beliefs about recovery
Inventory Phase	• Survivors recognize the limits of relief • Survivors begin thinking about their futures
Disillusionment Phase	• Survivors realize the reality of their losses • High stress played out through personally destructive acts, family tension, and community division • Potential for hostility between neighbors and among communities • Receiving assistance from relief agencies can be complicated and frustrating • Survivors feel powerless and angry
Reconstruction Phase	• Ongoing • Structural rebuilding • Adapting to lifestyle and environmental changes

As CRP staff members learned, however, there are significant differences between natural and man-made disasters in terms of the impact, recovery, and services that are provided. The disaster, which began September 11, 2001, cannot be characterized as a single event. Rather, it has encompassed a series of terrorist threats and actions designed to provoke widespread fear and anxiety among citizens in Virginia and nationwide. There is greater uncertainty than has been experienced before in the United States, due to the war on terror and the daily media barrage on possible future terrorist activity. The ongoing threat of current and future terrorist activities has led many otherwise healthy people to experience sustained anxiety manifested as fear, anger, and irritability.

The snipers brought back the fear that 9/11 started, which is that the government cannot protect the citizenry of this country. As public safety officials were looking for the snipers and assuring people to go about their regular business, there was also the feeling that they had no idea where they [the snipers] were, or who might be their next victim, and that's the very feeling that 9/11 generated and continues in our society. We still hear about the possibility of more 9/11-like attacks being carried out more than 2 years later.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

The people of the Commonwealth of Virginia confronted a series of traumatic experiences—grief, terror of death, disruption of daily life, anxiety, helplessness, uncertainty, and anger. Virginians have been attempting to cope with 9/11, as well as recovering from a series of traumas since then, such as the sniper attacks that occurred in October 2002.

When the first sniper shooting occurred in Maryland—few paid special attention to it; it was just another unfortunate random shooting. However, as the sniper shootings continued and moved into other parts of the DC metropolitan area and into Virginia, terror spread and intensified throughout the region. The snipers shot people as they pumped gas at filling stations, sat on a bus stop bench, or walked toward the school entrance. As a result, people feared open-space areas. Sporting events and many other outdoor events were cancelled. Lost opportunities, such as high school homecomings, can never be regained. Fear permeated the Washington, DC, area. People were anxious as they went about their daily lives. It took some time to realize that this, too, was terrorism and that it was causing tremendous fear and helplessness. For more information on the impact of the sniper attacks on the region, see below.

People are tired and they have a sense of living under a great deal more stress then they've had to. We've had the roller coaster of events following one after the other. People used to say that when you have a critical event then there's eventually a time when things slow back down. But living in the nation's capitol, in a place which is clearly armed and preparing for war, there's no way to go back, no sense of returning to normalcy.

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

The following October 9, 2002, CNN.com story provides more detail about the impact of the sniper attacks in the DC metro area.

'This is like a war zone': Recurring terror in D.C.

(CNN)—First, there was the crushing blow of hijackers ramming a plane into the Pentagon. Then there was the uppercut of anthrax attacks. That bio-terror shut down legislative buildings and post offices and killed two Washington D.C.-area residents.

Now a sniper is on the prowl. Six people are dead. Two more are injured.

Mental health professionals say such recurring terror can leave people in an embattled community such as the Washington environs on psychological ropes.

"I feel like this is a war zone we're living in," one Maryland resident told CNN. "President Bush is talking about fighting Iraq, and we have a war in this country he needs to deal with."

A barrage of stressful events sometimes weakens a person's ability to cope, said Dr. Charles Raison, an assistant professor in mind-body programs in the psychology and behavioral sciences department at the Emory University School of Medicine. People, who may have successfully staved off anxiety after one stressful occurrence, may not be able to withstand repeated terror-inducing situations, he said.

"There is a long of evidence that people who are exposed to one stress after another are more likely to develop stress-related disorders," said Raison, a psychiatrist. A common manifestation, he said would be a sense of fearful dread or horror.

Virginians and all Americans are still experiencing the threat of terrorism. There were many examples from the heroic and honeymoon phases following 9/11, but the Anthrax attack hurled the community back into the impact phase. The war in Iraq and the new threats of terrorism continue to generate fear and impede the recovery process. The ongoing nature of terrorism requires the disaster mental health worker to assess not only the impact of the current incident but past terrorist incidents in order to understand the circumstances in which they will be working.

Each of these events postponed in a lot of people the natural occurrence of mental health problems, especially post-traumatic stress disorders and other trauma disorders which we would expect to occur during the year to 2 years after the initial event. It appears that the timeline has been shifting because each new trauma puts people back to where they were earlier in their psychological recovery.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

Onsite Assessment

Upon arrival at the site, the disaster mental health worker is likely to meet with the setting manager and immediately be tasked with determining who needs help most. During this period, the mental health worker will be expected to set priorities; assess the environment, survivors, and workers; conduct interventions; and obtain closure. Yet, these opportunities and initial contacts at the site may be critical both to minimizing psychological trauma and to fostering resilience. Thus, the importance of conducting a thorough and thoughtful onsite assessment is critical to the immediate and long-term mental health of those affected.

One way to conduct a rapid onsite assessment is to conduct a "defusing." Applied under a slightly different context than the interventions described in Module 3, this term refers to the process of helping through the use of brief conversation. Because the site will likely be somewhat chaotic, defusing as a method of onsite assessment will probably consist of short conversations in passing, perhaps in line for coffee or while eating. Defusing allows the disaster mental health

worker to quickly "work the room" and assess which survivors, responders, or others might need additional support, reassurance, or information. It also provides the opportunity to assess and refer those who might need more in-depth social or mental health services. Finding unobtrusive ways to be in the vicinity of survivors and responders, such as handing out blankets or offering to get someone a soft drink, can help facilitate the defusing process and may also help a victim shift from survival mode to focusing on practical steps to restabilizing.

Disaster mental health workers may practice the following steps:[3]

- **Establish rapport.** Informal socializing is appropriate, such as asking, "Can I get you a soft drink or a bottle of water?" Do not ask for an account of the survivor's experience at this point, and avoid questions or statements that might be interpreted as condescending or trivializing, such as " How are you feeling?" or "Everyone is so lucky to be alive."

- **Conduct assessments.** Assess individuals' ability and willingness to shift from their current focus to social conversation. For example, notice if individuals are so preoccupied with their own practical concerns that they are unable to engage in light conversation with others. Ask open-ended questions related to their concerns, such as "How can I help you while you're waiting for more information?" or "I'm not sure if they're letting people back into the neighborhood, but I'd be glad to see if anyone has more information." During this exchange, evaluate how individuals respond to inquiries and whether they are following the conversation.

- **Gather facts.** Fact-finding can be an efficient means of quickly determining who is most at risk due to exposure to life threat, grotesque and potentially upsetting experiences, or other traumatic stimuli. Questions such as "Where were you when it happened?" and "Were there other people with you?" also are much easier for survivors to answer at this stage than questions asking them to relay their thoughts or feelings.

- **Inquire about thoughts.** Using the description of facts that the survivors have provided, ask probing questions about their associated thoughts, such as "What were your first thoughts when it happened?" "What are you thinking now that the immediate threat is over?" "Is there anything, in particular, that you keep thinking about?"

- **Validate feelings.** Inquiring about feelings at this time is probably not appropriate. Be cautious about asking these types of questions. The defusing in this context is meant only to provide useful information to enable the mental health worker to make a rapid assessment of needs. It serves as a brief intervention that precludes in-depth exploration and ongoing support. Therefore, it is important to avoid questions that might heighten a survivor's sense of vulnerability or cause overwhelming anxiety. Look for opportunities to validate common emotional reactions and concerns, providing assurance by helping the survivor to understand typical reactions to abnormal events and situations. While helping survivors to understand the common course of traumatic reactions will not bring closure to their experience, it may give the survivor a greater sense of control and may help to prevent emotional numbing or dissociation.

[3] Adapted from Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

- **Provide support and reassurance.** Though listed as the last step, providing support through reflective listening, dispensing information, and offering practical help should actually take place throughout the interaction. As the mental health worker moves to closure of the defusing, it is important to assess the survivor's support system to determine if a referral for social or mental health services is necessary. If a strong support system exists, emphasize the value that such social support can have in the recovery process. In addition, members of the CRP staff conveyed the idea that helping survivors recall their successful coping strategies for previously stressful experiences also was enormously helpful.

Working in a Disaster Environment

For a number of reasons, providing mental health services in a disaster environment can be very challenging. It may be difficult to identify a person in charge. There may be many people trying to provide assistance in seemingly uncoordinated efforts. It may be difficult to identify and gain access to those who need help most. In addition, as the response effort expands and the scene unfolds, these factors may be in a constant state of flux. This section provides guidance on how to identify the incident commander, or person in charge, as well as information on the national disaster response framework that helps coordinate large-scale response efforts to events involving mass casualties, such as natural disasters and acts of terrorism.

Declaring a National Disaster[4]

When the President declares a major disaster or an emergency, immediate notification is made to the Governor, appropriate Members of Congress, and federal departments or agencies. At that time, the President appoints a Federal Emergency Management Agency (FEMA) or other federal official as the Federal Coordinating Officer (FCO), and the Governor appoints a State Coordinating Officer (SCO). The immediate concern of the FCO and SCO after a declaration is to make an initial appraisal of the types of relief most urgently needed. The FCO coordinates all federal disaster assistance programs to ensure their maximum effectiveness and takes appropriate action to help affected citizens and public officials obtain the assistance to which they are entitled. This process is outlined on the following page.

[4] Federal Emergency Management Agency. FEMA 262: A guide to federal aid in disasters. Washington, DC, June 1997.

Disaster Declaration Process

- Incident occurs.
- Local government responds and contacts the state, if necessary.
- State government responds.
- If state resources are unable to provide adequate response, the Governor requests that the President declare a major disaster/emergency.
- The FEMA Regional Director confirms the Governor's findings.
- Regional findings and recommendations are given to the President.
- The President declares a major disaster/emergency, if necessary.
- The FEMA Associate Director appoints the FCO and designates areas eligible for federal assistance.
- The disaster program is implemented.

Coordinating a Response[5]

In the United States, a national response to large-scale traumatic events, such as natural disasters and acts of terrorism, is conducted through a coordinated approach involving local, state, and federal agencies. The Federal Response Plan (FRP) is the starting point from which all coordination decisions are made. The FRP describes how the administrators of 27 federal departments and agencies call up resources to support state and local response efforts. In particular, it details how states request and receive federal aid.

Once federal aid is approved, it is provided for specific functions that fall under 12 Emergency Support Functions (ESF), including firefighting, health and medical services, and mass care. Each of these functions is headed by an agency that may act as the lead coordinator at a terrorism site. Mental health services fall under ESF#8, Health and Medical Services, headed by the Department of Health and Human Services (DHHS). However, other agencies may lead the effort, depending on the nature of the event. The lead agency is often unclear until officially announced.

[5] Federal Emergency Management Agency. 9230-1-PL: Federal response plan, interim. Washington, DC, January 2003.

The table below lists each function and their lead agency.

Table 2–2. Emergency Support Functions and Lead Agencies

Emergency Support Function	Lead Agency
ESF #1—Transportation	Department of Transportation
ESF #2—Communications	National Communications System
ESF #3—Public Works and Engineering	U.S. Army Corps of Engineers, Department of Defense
ESF #4—Firefighting	U.S. Forest Service, Department of Agriculture
ESF #5—Information and Planning	Federal Emergency Management Agency
ESF #6—Mass Care	American Red Cross
ESF #7—Resource Support	General Services Administration
ESF #8— Health and Medical Services	Department of Health and Human Services
ESF #9—Urban Search and Rescue	Federal Emergency Management Agency
ESF #10—Hazardous Materials	Environmental Protection Agency
ESF #11—Food	Food and Nutrition Service, Department of Agriculture
ESF #12—Energy	Department of Energy

Establishing and Following the Leader

As a result of the preparedness planning described in Modules 1 and 7, the disaster mental health worker may be well-positioned within his or her local community and will have made the appropriate contacts within the local Emergency Operations Center (EOC) to ensure access to the site of the event. In addition, having introduced oneself to the appropriate points of contact before a disaster, and perhaps even integrating him- or herself into the local EOC, the mental health worker may gain access to copies of the state's initial assessment of the situation, as well as to the site itself to provide services.

The importance of having memoranda of understanding regarding operations is crucial in being able to sit at the table with an understanding of who is responsible for what. More importantly, what we were able to do was pull together a coalition of private and nonprofit agencies, and we kept each other apprised of who was providing what…and we could see that there was a lot of duplication of effort. So, while it felt chaotic in the beginning, because of the spirit of volunteerism and because so many people were very interested in doing the right thing in the right way, what could have been very chaotic turned out to be a relatively smooth operation.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

Because of the confusion and panic that characteristically result at the site of a terrorist attack, finding and reporting to the person in charge may be difficult, regardless of the contacts made in advance. However, if the event is suspected of being an act of terrorism, assume that a federal agency is coordinating the response and that the local EOC will be coordinating response efforts with the federal authorities. Prior to reporting for duty onsite, the local EOC should be contacted to assist the

mental health worker in identifying the appropriate authority in charge; that is, the person to whom he or she should report upon his or her arrival.

Working Alongside Others

It is also important to be aware of the other responders who may be present onsite. Some will perform very specific tasks, such as searching for survivors, driving ambulances, or directing traffic. Others will provide more general assistance, such as calming crowds and handing out supplies. Whether their roles are well-defined or not, chances are that the disaster mental health worker will work alongside and coordinate services with them. The table below provides an idea of who those other service providers might be.

In a given event, one never quite knows which institutions and which organizations will be involved in the response. In the 9/11 Pentagon response, for example, we had the military, so we had the federal government. We also had local jurisdictions as well as state jurisdictions. So, in the Pentagon disaster, each of those institutions had their own organizational rules and regulations for how to operate.

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Project Director, Arlington
Community Resilience Project

Table 2–3. Who Might Be Found Onsite

Local Response Public Agencies	• Fire and rescue department • Law enforcement • Local emergency management • Public works • Emergency medical services • Hospitals • Local officials • Survivor services • Human services
Local Response Private Agencies and Civilians	• American Red Cross • Salvation Army • Unmet Needs Committee • Community action groups • Good Samaritans • Clergy • Media • Employee assistance programs • Funeral homes

State Response	• State emergency management • State medical examiner's office • Public works • National Guard • Highway patrol • Public health • Governor's office • State attorney's office • State crime survivor compensation program • Consumer Protection Agency
***Federal Response**	• Federal Bureau of Investigation (FBI) • Bureau of Alcohol, Tobacco, and Firearms (ATF) • Office for Victims of Crime (OVC) • Federal Emergency Management Agency (FEMA) • Public Health Service (PHS) • Centers for Disease Control and Prevention (CDC) • Center for Mental Health Services (CMHS) • General Services Administration (GSA) • Small Business Administration (SBA) • Department of Veterans Affairs (VA)

*Note that many agencies are from a larger unit. CMHS and PHS, for example, are part of DHHS. Onsite, workers will probably identify themselves as being from CMHS or PHS, not DHHS.

Recognize that even when disaster mental health workers arrive a few minutes or hours after the event, there will likely be others already on the scene who are providing mental health support. Often, bystanders—with or without professional training—will attend to victims in a spontaneous way. Look for these "natural helpers" and join their efforts.[6]

The Role of the Disaster Mental Health Worker

Being Flexible and Resourceful

Every moment at the site provides a valuable opportunity for mental health workers to simply connect with someone who has been affected by the disaster. When approaching survivors, they should keep in mind that people may be preoccupied initially with basic life needs—where they will sleep tonight or why a child's babysitter doesn't answer the phone. Some may be unable or unwilling to explore their feelings and reactions. For more information on approaching individuals and appropriate interventions, see Module 3.

During the development of this training, CRP staff members were interviewed about the roles they played during the aftermath of 9/11, and asked what guidance they would provide other mental health workers who were preparing to provide services to survivors at the site of a terrorist attack. They cautioned that the disaster mental health worker should be prepared for the

[6] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

possibility of being met with an unwelcome reception. They explained that, just as mental health stigmas are common in some communities, the presence of a mental health worker in an obvious mental health capacity could make some people uncomfortable, unwilling to interact, and perhaps even more distressed. They shared further that, during the response to the 9/11 attack on the Pentagon, several mental health workers found that many military personnel who were present at the scene were reluctant to talk with them. One mental health worker, however, found a way to get past this barrier. She identified a gatekeeper—the military chaplain—who was onsite providing services to the military staff. She began working with him and, in doing so, found a much warmer reception from other military personnel because of that affiliation.

Self-Assessment

Aside from the mass casualties that may be terribly upsetting, the mental health worker may also be surprised at his or her own reaction to the act of terrorism. Mental health workers are not immune to the same feelings of shock, fear, and insecurity that others at the site will be experiencing. Should the disaster mental health worker go into the field in the immediate aftermath, it is important to keep in mind that continual self-assessment and processing with coworkers is key to maintaining mental health. See Module 6 for more information on self-care.

I don't think all of us are suited to being actively involved in disaster work. So, people have to honestly assess themselves and determine if they like to be in a hectic, non-structured setting, not knowing exactly what [their] duties are going to be. One needs to be spontaneous, reacting quickly to the needs that are presented. One also needs to be a person that can really go with the flow and also do some things that are not what a therapist would do. There are roles after disasters, such as counseling victims and secondary victims in the days, weeks, and months afterwards. You don't have to actually go to the scene to be a valuable part of what the community needs to recover.

Donna M. Foster, M.S.W.
Project Director, Fairfax County
Community Resilience Project

Summary

The impact of terrorism is felt far beyond those directly affected by the event. Thus, providing effective mental health services to survivors requires the ability to recognize the extent of terrorism's reach into a community and to respond appropriately for the mental health of individuals and the community. Responding appropriately in the early stages following terrorism primarily involves being available, supportive, and reassuring. The challenge for disaster mental health workers who have been trained to deal with pathological dysfunction is to take a supportive role in a nonclinical setting. This requires the ability to conduct a rapid onsite assessment and determine which of the many roles a disaster mental health worker may play. It also requires an understanding of the pattern of phases of recovery that may follow a catastrophic event, and recognizing that reactions may differ depending on variables such as the nature of the mass trauma event. Having a general familiarity with the Federal Response System and how to navigate it to increase access is also key in providing effective mental health services.

You can be involved in the beginning after an incident, when things are very intense at ground zero, in helping the first responders and others deal with their difficulties and, of course, the victim's families, the people who are at the site, and so forth. But mental health practitioners need to allow themselves to decide if that's the way they can best contribute. There are many other ways a mental health practitioner can respond. They can provide ongoing services, supportive services, grief services. They can decide to specialize in PTSD and other kinds of disorders that might require services 6 months, a year, or longer after the event, but they would still be very much a part of the provision of services.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

Additional Resources

Appendix A: Weapons of Mass Destruction 101.

Are you ready? A guide to citizen preparedness, Federal Emergency Management Agency, http://www.fema.gov/areyouready/

CDC Public Health Emergency Preparedness and Response, http://www.bt.cdc.gov/

Unit 8: "Terrorism and CERT," community emergency response team instructor guide, Federal Emergency Management Agency, Emergency Management Institute, http://www.training.fema.gov/emiweb/cert/mtrls.asp

U.S. Department of Homeland Security, http://www.ready.gov/get_informed.html

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

MODULE 3: INTERVENTIONS/SERVICES

Do you take the pictures down? Do you get rid of their clothes and toys? What do you do when people ask 'Do you have children?' I don't have any answers.

—Edye Smith, Mother of Chase, 3, and Colton, 2, who were killed in bombing of the Alfred P. Murrah Building, Oklahoma City, Oklahoma, April 19, 1995[7]

The field of disaster mental health services is continuously evolving as new experiences provide additional evidence. While there are still gaps in the research on the effectiveness of early interventions, much research has been conducted on the effectiveness of intervention approaches and a range of services have been found to be appropriate. Disaster mental health experts and practitioners agree there is no one best mental health intervention; the interventions must be tailored to the unique experiences and the needs of the affected individuals and community. This is especially true when it comes to response to terrorism, where no two events are ever the same.

Experienced emergency services workers may already be familiar with much of the material presented here. New aspects may be the context in which these services are provided, the populations served, as well as the approach of assisting the community with a model based not on pathology but on a wide range of natural responses.

As a clinician, I think the most important thing is that one should not expect that, simply because one has a degree in mental health services, one can do trauma work. It really takes a little bit, not a lot, but some special training to provide these services to the public in an ethical way and in a way that is beneficial to recovery.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

Disaster mental health assistance needs to be practical, flexible, empowering, and reflect survivors' needs to pace their exposure to harsh realities resulting from the event. While most survivors will experience normal traumatic stress and grief reactions, a significant minority will experience serious longer-term psychological difficulties. To make appropriate decisions about service provision, it is important to understand the range of reactions. The overwhelming fear associated with terrorism affects the services utilized and the way they are provided.

A variety of mental health interventions have been identified as common and accepted approaches during a terrorist event response. Deciding which approaches are used will depend upon the phase of recovery from terrorism (see Module 2, Table 2–1). For example, during the impact phase, immediately after a disaster, the focus might be on psychological first aid, whereas psychoeducational approaches may be more beneficial during the phases of reconstruction and working through grief. Some possible approaches include:

[7] (1995). Requiem for the heartland the Oklahoma City bombing. San Francisco: The Tides Foundation and Collins Publisher.

- Psychological first aid
- Crisis intervention
- Informational briefings
- Psychological debriefing
- Psychoeducation
- Community outreach
- Brief counseling interventions
- Support and therapy groups
- Mental health consultation
- Support role during death notification

After completing this module,[8] a disaster mental health worker will be able to:

- Identify common and more problematic reactions to terrorist events
- Understand the key principles of disaster mental health response
- Identify interventions that are appropriate following a terrorist event

Reactions to Terrorist Events

Most people experience typical reactions to terrorism and traumatic events. It is critical to reassure survivors that their reactions are normal, regardless of how they may feel. Terrorism and traumatic events activate the body's survival response, i.e., fight, flight, freeze. As this response unfolds, people behave in a variety of ways and have a wide range of experiences. For most people, the return from crisis to everyday functioning is an automatic process requiring little or no intervention. It is important to understand when to simply allow the process to unfold naturally, when to intervene, and when to refer.

[8]Much of the information is adapted from DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Dr. Deborah DeWolfe, a veteran disaster mental health worker, interviewed disaster mental health workers from across the country and studied current research and literature to determine what were the common and accepted best practices. Community Resilience Project staff added to this material from their experiences in responding to 9/11.

Common Reactions to Trauma

The following chart organizes, by age, typical cognitive, behavioral, physical, and emotional reactions to traumatic events.

All Ages

- ❑ Anger
- ❑ Anxiety
- ❑ Appetite changes
- ❑ Colds or flu-like symptoms
- ❑ Concentration problems
- ❑ Fear of crowds or strangers
- ❑ Fear of darkness
- ❑ Feelings of hopelessness
- ❑ Guilt
- ❑ Headaches
- ❑ Mood-swings
- ❑ Nausea/stomach problems
- ❑ Nightmares
- ❑ Poor work performance
- ❑ Confusion
- ❑ Crying easily
- ❑ Denial
- ❑ Fatigue
- ❑ Fear of being left alone
- ❑ Hyperactivity
- ❑ Hyperviligence/increased watchfulness
- ❑ Increased drug and alcohol use
- ❑ Irritability
- ❑ Isolation
- ❑ Reluctance to leave home or loved ones
- ❑ Sadness
- ❑ Sensitivity to loud noises
- ❑ Sleep difficulties

Children of All Ages

- ❑ Anxiety and irritability
- ❑ Clinging, fear of strangers
- ❑ Fear of separation, being alone
- ❑ Head, stomach, or other aches
- ❑ Increased shyness or aggressiveness
- ❑ Nervousness about the future
- ❑ Regression to immature behavior
- ❑ Reluctance to go to school
- ❑ Sadness and crying
- ❑ Withdrawal
- ❑ Worry, nightmares

Preschool Age (1–5)

- ❑ Changes in eating habits
- ❑ Changes in sleeping habits
- ❑ Clinging to parent
- ❑ Disobedience
- ❑ Fear of animals, the dark, "monsters"
- ❑ Hyperactivity
- ❑ Speech difficulties
- ❑ Regression to earlier behavior (thumbsucking, bedwetting)

Early Childhood (5–11)

- ❑ Increased aggressiveness
- ❑ Changes in eating/sleeping habits
- ❑ Difficulty concentrating
- ❑ Regression to earlier behavior
- ❑ Competing more for the attention of parents
- ❑ Fear of going to school, the dark, "monsters"
- ❑ Drop in school performance
- ❑ Desire to sleep with parents

Adolescence (12–14)

- ❑ Abandonment of chores, schoolwork, and other responsibilities previously handled
- ❑ Disruptiveness at home or in the classroom
- ❑ Experimentation with high-risk behaviors such as drinking or drug abuse
- ❑ Vigorous competition for attention from parents and teachers
- ❑ Resisting authority

Problematic Reactions

The following may indicate the need for more extensive intervention and counseling:

- ❑ Disorientation—dazed; memory loss; inability to give date or time, state where he or she is, recall events of the past 24 hours, or understand what is happening
- ❑ Inability to care for self—not eating, bathing, or changing clothes; inability to manage activities of daily living
- ❑ Suicidal or homicidal thoughts or plans
- ❑ Problematic use of alcohol or drugs
- ❑ Domestic violence, child abuse, or elder abuse
- ❑ Any common reaction may require intervention if it interferes with daily functioning

Risk Factors for Problematic Reactions to Trauma[9]

The following are risk factors at different stages of a terrorist event that may help identify individuals and groups who are more susceptible to having a more problematic stress response. Additional, immediate outreach and intervention efforts may be needed in these situations.

Personal Risk Factors Before Trauma

- Past history of Posttraumatic Stress Disorder (PSTD)
- History of childhood abuse
- Early attachment issues
- Family history of trauma
- Psychological difficulties
- History of substance abuse
- Female gender
- Younger age
- Low socioeconomic status
- Lower intelligence

Personal Risk Factors During Trauma and 24 Hours After Trauma

- Degree and intensity of exposure
- Dissociation
- Intrusion and avoidance
- Depression
- Hyperarousal
- Negative self-talk
- Lack of immediate social support

[9] Adapted from presentations made by Dr. Rony Berger, Psy.D., at Natal Israel Trauma Center for Victims of Terror and War, on June 11 and 12, 2002.

Personal Risk Factors After Trauma

- Lack of societal acknowledgment
- Lack of ongoing social support
- Stressful life events
- Unproductive family patterns

One of the things that we've seen, and this is consistent in our work with individuals and groups, is that people are sensing greater anxiety, which manifests in many ways, in terms of physical symptoms, not feeling well, headaches, tension…It's pervasive. I think that everywhere we go in the Washington area, people are living with a sense of still feeling hyper-alert.

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

Dynamics of Symptoms Over Time

Post-event traumatic reactions may be:

- Intense or mild
- Immediate or delayed
- Cumulative in intensity
- Reactivated by:
  - Subsequent traumatic experiences
  - Reminders of the event:
    - Anniversaries
    - Area or object associated with the event (e.g., planes, building)

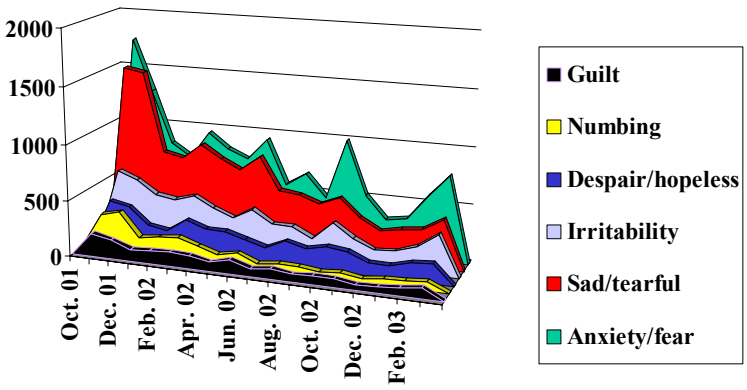
Symptoms may also be activated by vicarious trauma, such as media exposure or contact with people involved in the terrorist event.

Patterns of Reactions in Northern Virginia After 9/11

The following charts demonstrate the pattern of reactions experienced in Northern Virginia by people who received individual crisis counseling services from the Community Resilience Project during the 18-month period following 9/11. Each chart shows the number of people experiencing or exhibiting the described reactions. During that time period, Northern Virginians experienced the anthrax attack, sniper attacks, terrorist alerts, and the war on terror. Each new event created a surge in reactions and services. The peaks in reactions around October 2002, for example, were in response to the sniper attacks, and in March 2003, to the heightened security alerts followed by the war on terror. Each of these events contributed to fear and anxiety, and created hypervigilance throughout the community. A number of the sniper attacks occurred in shopping areas and gas stations. In an attempt to make it difficult to be shot, people were doing what was referred to as the "bob and weave" while walking to the shopping center or were crouching beside their car while pumping gas. Thus, the chart displays a peak in hypervigilance at this time.

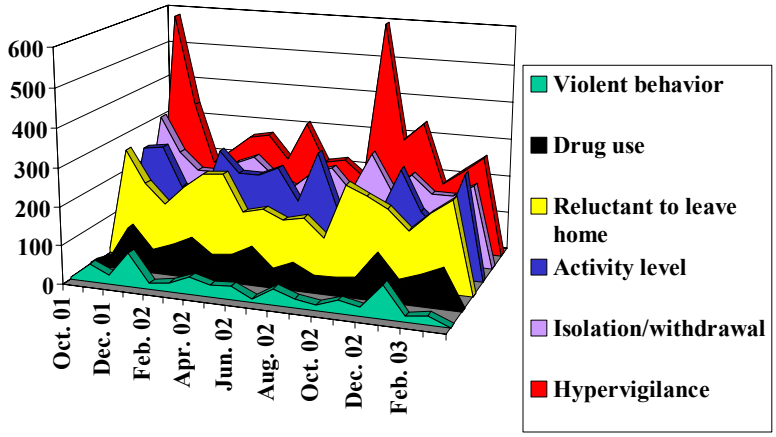
Using a medical metaphor, the healing process was not progressing in the community as anticipated post-9/11 because the "scab" had not been allowed to fully form and heal. Not only did these events evoke trauma in the region, but people responded to the government and media reports as though the next terrorist event was just around the corner. Reminders were everywhere, such as digital warning signs posted above interstate highways that read: "Report Suspected Terrorism 1-866-XXX-XXXX"

Community Resilience Project of Northern Virginia
COMING TOGETHER TO HEAL



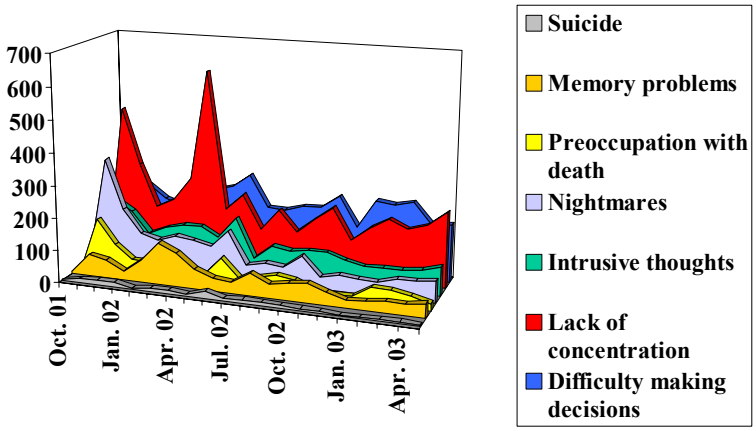
Community Resilience Project of Northern Virginia
COMING TOGETHER TO HEAL

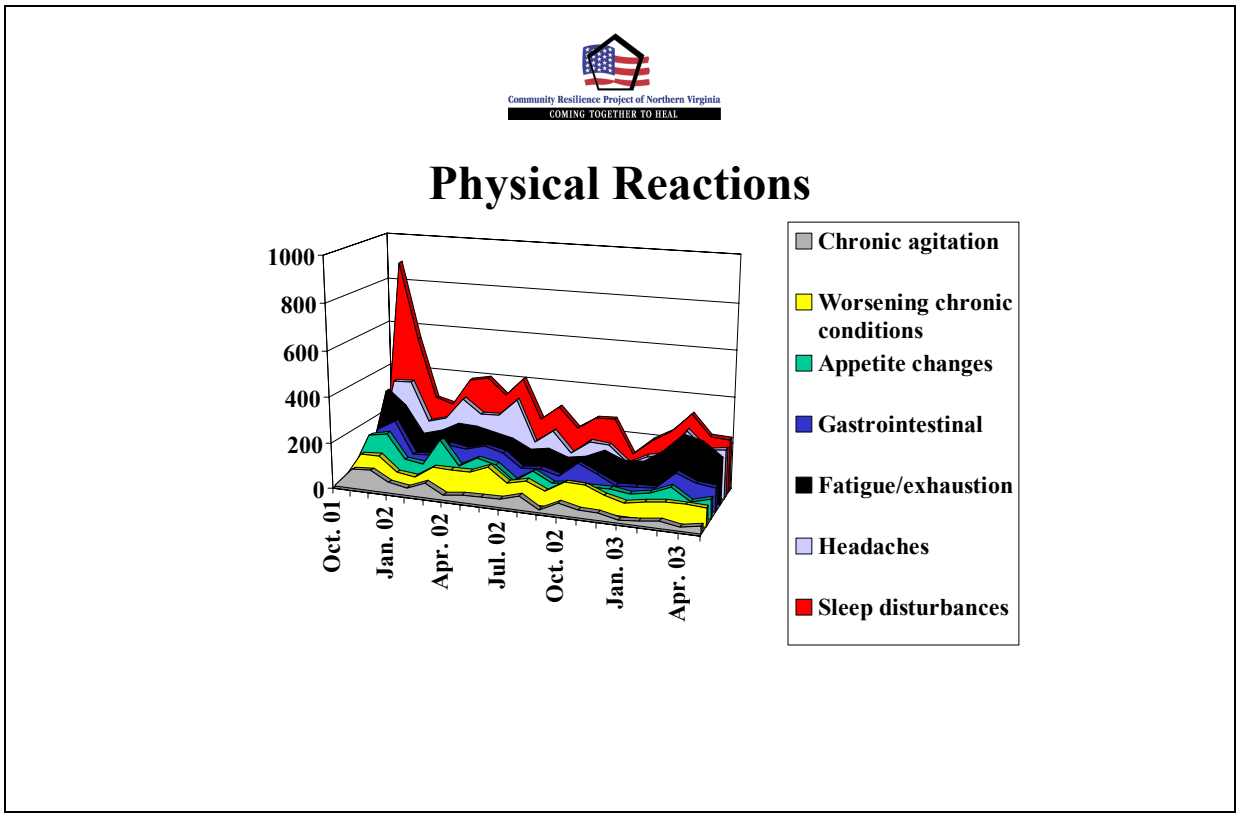
Behavioral Reactions



Community Resilience Project of Northern Virginia
COMING TOGETHER TO HEAL

Cognitive Reactions





Key Principles for Disaster Mental Health Intervention

1. **Do no harm.** First and foremost, mental health workers must assess an individual's needs with great sensitivity. Accepting and validating a person's reactions in the moment are critical to avoid disruption of the natural healing process. When in doubt about the level of intervention, err on the side of caution.

2. **Assume resilience.** Human beings are very resilient. The goal of disaster mental health intervention is to support and empower people as they access the strengths and coping mechanisms that have given them strength and comfort in the past. For example, assisting individuals in connecting with family or other existing support networks can help them cope with the effects of the trauma.

3. **Everyone who experiences a terrorist event is affected by it.** A terrorist event has far-reaching implications. People may be directly affected by being at the site or by losing a loved one. They may also be indirectly affected by exposure to media, hearing someone's story, reactivation of past trauma, or the ripple effect (such as economic impact).

4. **Simple human presence is powerful and reassuring.** Providing emotional safety by being quietly present can be valuable following exposure to trauma. Mental health services following a terrorist event are aimed at acknowledging health and normalizing individual responses versus actively seeking out pathological reactions. Simply being present with people may initially seem insufficient or less important than traditional mental health therapy, yet this service can do much to minimize long-term traumatization.

5. **Be culturally competent.** Having knowledge and awareness of the diversity that exists within the community one intends to serve is crucial. To provide competent services as a mental health worker, it is important to educate oneself regarding each individual's cultural history, norms, values, belief systems, language, traditions, and view of the trauma/grieving processes. In addition, mental health workers need to explore and understand their own backgrounds, biases, and value systems. This exploration is important to ensure that mental health workers are comfortable with different points of view and are able to provide nonjudgmental services.

6. **Terrorist attacks affect both individuals and communities.** In some cases, the effect can be positive and empowering, as community members realize they can join together to cope effectively with difficulties. Terrorist attacks can negatively affect the functioning of social institutions, which, in turn, can interfere with individual recovery. Facilitating the recovery of the community as a whole affects the individual's ability to heal. The dynamics of this process will vary with the particular nature of the disaster. Certain groups may become scapegoats or be targeted for victimization, thereby affecting overall community functioning.

7. **Respect individual differences in moving through traumatic reactions.** Every individual has his or her own process of recovery that may be appropriate for that person. Some people may not exhibit traumatic reactions initially and may remain in a state of immobility or denial for a longer period of time. Accepting and respecting a person's pace of progress is crucial. It is to be expected that, at any point, some people may reject services and this may be a healthy response to their individual needs. In some cases, on the other hand, symptoms may not arise for months or years after an event.

8. **Services are enhanced by a flexible approach that includes ongoing assessment, evaluation, and revision.** Each community has unique requirements that can be discovered only through accurate assessment. In addition, needs for services change as recovery progresses. Creativity, responsiveness, and flexibility are key elements to effective service delivery.

9. **Development of a team approach is vital to effective functioning.** People on the disaster mental health team bring a variety of perspectives and points of view that, as a whole, reflect the community they serve. This variety allows the team to better assess the needs of the community as it moves through the process of recovery. In addition, people bring different talents to disaster recovery planning. Members of a team can be mutually supportive in maintaining optimal functioning, motivation, and direction as well as in addressing issues of vicarious trauma.

10. **Mental health services must be coordinated with the larger response-recovery team which may include fire, police, rescue, and recovery agencies**. Mental health workers have an important role to support the first responders and provide immediate services to victims when appropriate. The coordination of mental health response with other agencies in an emergency situation is essential. Efforts to organize these services need to be addressed in most communities. If the response and relief agencies fail to coordinate efforts, they can frustrate or anger the survivors. Coordinating mental health services with the agencies involved in these processes is important to helping survivors cope.

Range of Interventions/Services[10]

At different phases of the post-disaster environment, various types of interventions will be appropriate. The following information provides guidance on the appropriate range of services for use with adults, older adolescents, and older adults.

At the scene of a terrorist event, facilitating physical and emotional safety is the primary objective. A common response of many survivors is to feel highly vulnerable and fearful; therefore, interventions emphasize protection and safety as well as promote a sense of security. The four initial intervention goals are:

- Identify those in need of immediate medical attention
- Provide supportive assistance and protection from harm
- Facilitate connecting survivors with family and friends
- Provide information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts

Once safety is established, the following four intervention goals should be targeted:

- Alleviate distress through supportive listening, providing comfort, and empathy
- Facilitate effective problem-solving of immediate concerns
- Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor
- Provide psychoeducational information regarding post-trauma reactions and coping strategies

Psychological First Aid[11]

Rapid assessment is conducted to identify the survivors who are most acutely distressed and in need of medical attention. Initially, triage decisions are based on observable and apparent data. Persons experiencing physiological reactions like shaking, screaming, or disorientation may need to receive emergency medical attention. Medical assessment and assistance are necessary for older adult survivors who are vulnerable because of health conditions and physical or cognitive limitations. People who appear profoundly shut down, numb, dissociated, and disconnected may also require medical attention.

Psychological first aid involves three basic concepts: protect, direct, and connect.

[10] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[11] Ibid.

- Survivors need to be **protected** from viewing additional traumatic stimuli from the event. In addition, they need to be protected from curious onlookers and the media.

- When disoriented or in shock, survivors need to be **directed** away from the trauma scene and danger, and into a safe and protected environment. A brief human connection with a disaster mental health worker can help to orient and calm them.

- Disaster mental health workers assist survivors by **connecting** them with loved ones, as well as with needed information and sources.

Psychological support involves:

- Addressing immediate physical necessities

- Comforting and consoling the survivor

- Providing concrete information about what will happen next, thus increasing a sense of control

- Listening to and validating feelings

- Linking the survivor to support systems

- Normalizing stress reactions to trauma and sudden loss

- Reinforcing positive coping strengths

- Facilitating some telling of the "trauma story," as appropriate for the survivor

- Supporting reality-based, practical tasks

Crisis Intervention[12]

While sharing elements of psychological first aid, crisis intervention aims to empower survivors so that they may effectively address immediate challenges. Crisis intervention typically involves five components:

- Promote safety and security

- Invite the person to share their experience

- Identify current priority needs, problems, and possible solutions

- Assess functioning and coping

- Provide reassurance, normalization, psychoeducation, and practical assistance

[12] Ibid.

Promote safety and security. Survivors need to feel protected from threat and danger. When given simple choices, many come to feel empowered as they exercise some control over their situations—a critical step for engaging initial coping and internal organization. For example, ask:

- *May I get you something to drink?*
- *Are you feeling comfortable/safe here?*

Invite the person to share his or her experience. For many, verbalizing emotions, reactions, and experiences is therapeutic and an important step toward coping with the situation. Ask the individual:

- *If you want to talk about what happened, I would like to listen.*
- *Where were you when it happened?*
- *How have you been reacting and feeling?*

For those who are highly distressed, however, talking in much detail about their disaster experience and expressing related emotions might be retraumatizing. People may not be ready to express their emotional reactions. Just being with someone can be a great comfort.

If the person is able, provide reassurance and comfort, and move on to problem-solving. Often, practical matters need to be addressed. For example, someone may need to notify relatives and friends of the loss of a loved one, fill out insurance forms, pay bills, or notify his or her employer that he or she will need to be on leave of absence for a period of time. Disaster mental health workers can help the person to begin to prioritize and problem-solve the many practical decisions that need to be made.

Identify current priority needs, problems, and possible solutions. Selecting one solvable problem as most immediate and addressing it successfully can help to bring back a sense of control and capability. Identifying potential sources of support among friends, family, faith organizations, health care providers, or the community may be helpful. Probes might include:

- *Describe the problems/challenges that you are facing now.*
- *Who might be able to help you with this problem?*
- *What has helped you in the past work through a serious problem?*

Assess functioning and coping. Through observing, asking questions, and understanding the survivor's past and current problems/losses, develop an impression of the survivor's ability to address challenges. Based on this assessment, consider making referrals, pointing out coping strengths, and encouraging the survivor to seek support. Ask the survivor:

- *How are you doing?*
- *How do you feel about how you are coping with this?*

- *How have you coped with stressful life events in the past?*

Provide reassurance, normalization, psychoeducation, and practical assistance. Reassurance and normalization of feelings and reactions occur throughout the intervention. It is extremely important that the survivor feels that the response received is personal. Pay close attention to his/her experience and style, and do not offer "canned" responses. Psychoeducation should address the particular reactions mentioned by the survivor and may provide additional information through a pamphlet or individualized information. A sample statement might be:

- *The way you're feeling is normal.*

Informational Briefing[13]

Survivors will seek information about the location and well-being of their loved ones, levels of threat and danger, procedural information, criminal investigation updates, etc. Disaster mental health workers do not provide informational briefings, but they may consult officials about the need to do so and offer to be present to provide support, as needed. They may also encourage officials to ensure that cultural and ethnic groups have access to these briefings. Also, they may offer suggestions to officials about:

- Appropriate language/terminology
- Level of detail for sensitive information
- Approaches for addressing intense emotional reactions
- Language to use in conveying messages of compassion and condolence

For more on communicating during a crisis, see Module 5.

Psychological Debriefing[14]

Psychological debriefing is a group intervention that has been used with a wide range of groups, including emergency responders, highly exposed survivors, community bystanders, and groups from the larger affected community. It involves a series of stages that move participants from a more cognitive consideration of the traumatic event, to discussion and expression of emotions and reactions, and then back to more cognitively focused learning about coping and problem-solving.

Components of psychological debriefing include:

- The facilitator introduces the process and ground rules
- The participants describe the stories of their involvement with the event

[13] Ibid.
[14] Ibid.

- The participants describe their thoughts, feelings, and reactions during and since the event
- The facilitator validates and normalizes reactions, and provides psychoeducation
- The facilitator wraps up the session by addressing issues, distributing brochures on stress and coping, and discussing when and how to seek professional help

Facilitation of an effective psychological debriefing requires more clinical skill than simply knowing and following the steps. Specific training for conducting these group interventions, as well as partnering and supervision with an experienced facilitator, is strongly recommended.

Participation in a debriefing should be completely voluntary and follow up is necessary—the debriefing should not be an intervention in isolation but one element of a comprehensive and sustained support program.

Ensure that the group is composed of persons linked socially via working relationships or prior friendships rather than merely grouped by geographical proximity at the time of the scheduled debriefing. Reduce individual isolation and foster group cohesion with an open and frank discussion among care providers or persons concerned with the well-being of participants. Focus on "what happened" by creating a cognitive historical narrative of the event. Participants should be allowed to express their feelings, if they choose, and those feelings should be supported. *Any attempt to extract the real or underlying emotions is strongly discouraged.* Those with prior abusive experience, minimal ability to regulate affect, limited ego-functioning, or serious preexisting mental illness may be harmed by being forced to participate in highly emotional, mandatory debriefings.[15]

It is recognized that, at the time of this writing, the literature reflects ambiguous results regarding the effectiveness of this particular modality.

Psychoeducation[16]

Psychoeducation for survivors, health care providers, and providers of community services is a core component of mental health response. Information is typically provided about:

- Post-trauma reactions, including "normal reactions to abnormal situations"
- Grief and bereavement
- Effective coping strategies
- Indications of when to seek professional help

[15] Lacy, T.J. and Benedek, D.M. (2003, May). Terrorism and weapons of mass destruction: Managing the behavioral reaction in primary care. Southern Medical Journal. 96(5):394-399.
[16] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Material should be specifically oriented to the actual event and locale, as well as adapted for each group or population so that it is age-appropriate and culturally appropriate. All forms of the media are used to disseminate information. Psychoeducation should be based on the survivor's presenting concerns.

Educational presentations are offered to schools, senior centers, community and recreation centers, faith organizations, and at many other community events. Parents, teachers, and caregivers often ask questions on how they can best help children. Help them recognize reactions of children in various age groups and provide them with strategies to help the children cope.

Community Outreach[17]

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism. Within hours of the event, survivors and their families may be geographically dispersed. Disaster mental health workers need to consider the nature of the event and its impact, and develop a flexible plan for community outreach.

The sniper incidents the year after the terrorist attacks, for example, heightened the fear already felt by many Northern Virginia residents. Community outreach was a key service during this period because the public was eager for support and information on how to cope. An outreach team from the Alexandria Community Resilience Project (CRP) distributed the "Coping with Sniper Attacks" brochure at area gas stations, strip malls, and other locations. Community members who received the brochure were thankful, and many shared their feelings and reactions with project staff.

Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors through the media, the Internet, and maintaining 24-hour telephone hotlines with responders who speak different languages
- Participating in or conducting meetings for preexisting groups through faith communities, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers

We conducted a lot of classes for a whole variety of different organizations, businesses, churches, [and] schools on stress management. So we provided a lot of stress management and, from that, it was really interesting how we were able to draw people that needed the help, and refer them, and actually even get into other areas and communities that needed the help we could provide.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

[17] Ibid.

Community outreach requires:

- Ability to initiate conversations with those who have not requested services
- Good interpersonal skills
- Ability to quickly establish rapport, trust, and credibility
- Ability to think on one's feet
- A sense of diplomacy
- Knowledge and respect of values and practices of cultural groups affected by the event

Reaching the Unemployed

Unemployment in Northern Virginia increased due to the post-9/11 economic downturn. Employers in the area, including those in the travel and tourism business, imposed layoffs that created added stress for many residents. To reach these workers and offer emotional support and referral assistance, CRP counselors went to local job centers and state unemployment offices.

In Fairfax County, CRP staff kept regular hours at an apartment complex inhabited by many service and travel industry workers. The community, which has a history of crime, domestic violence, and racial tensions, was hard hit by the 9/11-related loss of jobs at nearby Dulles Airport. CRP staff focused on one-on-one counseling and participated in employment fairs and referrals.

Community outreach efforts may include:

- *Community memorial and commemorative events.* A disaster mental health worker may help with the planning of community memorial and commemorative events. It is critical that the role is that of a consultant rather than a director. Survivor and community ownership of the event enhances its meaning and significance. A disaster mental health worker may:
  - Suggest strategies for including children or other special survivor groups
  - Alert planners to the potential for misunderstanding or for alienating survivors or groups through the use of particular language or symbols
  - Attend these events and be available to provide psychological support as needed and requested
- *Usual community gatherings.* Continuation of usual gatherings or events, such as community parades, school plays, or church fairs, promotes hope and the sense that the community can overcome harm and recover. Decisions to cancel or postpone these events must be made carefully, as they provide valuable opportunities for social support and healing. A disaster mental health worker may:
  - Assist community leaders in determining whether to hold an event

  - Offer suggestions for ways to adapt the event so that it appropriately acknowledges the community tragedy

- *Symbolic gestures.* Symbols can have profound significance for people who wish to communicate gratitude and good will or who are searching to find meaning, courage, and hope. Simple gestures can become powerful conveyors of compassion and condolence. A disaster mental health worker may:

  - Assist affected groups to develop symbols

  - Provide assistance with the logistics to carry out an idea

- *Materials and activities targeted toward different populations.* Members of different populations, including different age and racial/ethnic groups, exhibit varied reactions to tragic events. To tailor a mental health response to their backgrounds and needs, a disaster mental health worker may:

  - Form a multicultural outreach team to distribute information in the community and make presentations

  - Develop brochures in multiple languages and distribute them in locations frequented by different groups, e.g., neighborhood gas stations, grocery stores, strip malls, libraries, schools, and other public areas

Experience is always the best teacher. 9/11 has been a unique experience. Even in the Oklahoma City disaster, it was a different kind of situation. It was a one-time event by people who were later captured and put in jail. The 9/11 experience was not just an event, but it started a process which has had other incidents and also has had a different climate attached to it. We didn't know that there were going to be all these other events. We didn't quite anticipate the complexity of the dynamics of our community, in terms of having so many different groups, particularly ethnic groups who have come here relatively recently and who were so acutely and intensely affected by the events themselves, and [who have] an ongoing sense of vulnerability to further attack… We had to do a lot of customizing of the services that we've provided, changing the venues, the content of our presentations, and providing staff who were familiar to the community with which they worked.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

- Conduct life skills workshops with topics on stress management and how to cope with reactivated fears from survivors' experiences in their native countries
- Conduct cross-cultural dialogues
- Provide life skills training for youth at recreation centers, family resource centers, and juvenile detention/post-detention facilities
- Work with youth to write and produce plays or other creative activities based on their experiences and feelings

There was one man at the airport…We had come out to the airport several times [to give classes on stress management], but he came to us afterwards and said that the information that we had given him was actually life-changing, that it had helped him calm down. It helped to put things into perspective. A lot of the stress management techniques that we taught people were really, really helpful and were exactly what they needed.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

We do a lot of work in neighborhoods with teens, working on issues about anger management and where anger comes from, like using anger to work out our stress and our fear. And so one of the things that is really a focus of our anger work is to help teens tap into sources of that fear and to talk in very safe and comfortable ways, with folks that speak their language, about more positive ways to work out those feelings.

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

Outreach Can Happen Anywhere, Anytime

The cumulative stress of all that has happened here in Northern Virginia is demonstrated in how people relate with one another within the community. The following describes an experience of an Arlington County CRP outreach worker and demonstrates that treatment, although important, is only one element of a mental health response to terrorism. Community healing is as important as treatment. Outreach workers can be of assistance in a formal way or on the spur of the moment.

Publicly distributing pamphlets about Islam in front of a subway station can mean exposing oneself to the possibility of persecution—especially in one of the counties where the deadliest terrorist attack in United States history took place. The pain is still fresh, the suffering continues, and many believe Islam is to blame, yet this man was suffering too. In my role as an Outreach Counselor for the Arlington CRP, I gladly accepted one of his pamphlets and gave him one of ours. Anxiety was evident in his voice and his eyes as he began speaking urgently to me of the peaceful nature of his religion, as though he longed to announce to the whole world that he is neither guilty nor responsible for this tragedy. Tension rose as we were approached by another man, who loudly and unabashedly expressed anger at those who use religion to "mess up the world." I relied on the crisis counseling training I had received to listen supportively and understand the root of his anger. The anger turned to sadness as he spoke of the horrors he had suffered as a soldier in Vietnam. Slowly, the initial conflict between the two men began to melt away, as they both expressed a hatred of the suffering caused by war, a solidarity for both having experienced it personally, and an appreciation for those who dedicate their lives to ease the pain of others. I watched them exchange a handshake and words of respect. They each left with a CRP brochure, a renewed sense of good will, and the knowledge that support is available. I left with an admiration of the inner strength of the people of this community, satisfaction that doing my job had met the important need of helping them find that strength, and an even greater pride that I call this place home.

Brief Counseling Interventions[18]

The therapeutic goals of brief counseling interventions involve the following:

With the sniper event, we had a lot of parents calling in saying, "How I do talk to my children about this?" "How do I reassure them?" "What can I do?" "Do you have information for me?" For some of them, we would do brief crisis counseling. With others, we just sent materials; they felt that was all they needed, just some tools.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

- Stabilizing emotions and regulating distress
- Confronting and working with the realities associated with the event
- Expressing emotions during and since the event, including anger, anxiety, and fear
- Understanding and managing post-trauma symptoms and grief reactions
- Developing a sense of meaning regarding the trauma
- Coming to accept that the event and resulting losses are part of one's life story

The most therapeutic approaches recognize that the survivor's capacity to confront painful realities and intense emotions develops gradually; therefore, the treatment process must move at a rate that is comfortable to the survivor.

[18] Ibid.

Counseling may use a particular treatment approach or be multi-modal and incorporate a combination of different approaches. Treatments commonly used for post-traumatic stress and traumatic bereavement include:

- Cognitive-behavioral therapy
- Phase-oriented treatment
- Bereavement counseling
- Eye movement desensitization and reprocessing
- Brief therapies
- Psychopharmacology

These modalities have varying levels of scientific evidence supporting their efficacy. Many mental health professionals attempt to match the treatment approach with its perceived acceptability and helpfulness to the client.

Creative Approaches to Connecting with Community Members

Mental health outreach workers are encouraged to initiate strategies that make it easy and comfortable for community members to tell their stories, such as:

- Attendance at workshops for people who are seeking financial assistance demonstrates an active interest in the reality of their situation. Individuals are likely to accept this kind of help before they will talk about their personal feelings. When offering this level of help, the disaster mental health worker will quickly discover that survivors readily begin talking about their experience.
- Project Liberty, a program established in New York City to provide free crisis counseling services to those affected by 9/11, found that the following interventions created additional opportunities to reach survivors:
  - **Online or "Intherapy" interventions.** Interventions provided through the Internet were particularly effective with youth audiences as well as with Project Liberty and EMS workers who preferred anonymity.
  - **Phone interventions.** Phone interventions helped improve access to those unable to leave their homes.

Support and Therapy Groups[19]

Group treatment is especially appropriate for survivors of terrorist events because of the opportunity for social support through the validation and normalization of thoughts, emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others can be powerfully helpful. In addition, group reinforcement for using stress management and problem-solving techniques may promote courage and creativity. Sharing information about service and financial resources, as well as other types of assistance, is another important function of support groups.

[19] Ibid.

Groups may be offered for parents, children, members of a particular neighborhood, a particularly affected occupational group (such as the airline industry after 9/11), or survivors who suffered a particular trauma or loss (e.g., bereaved parents).

Grief counseling is an important component of group services. The Community Resilience Project found some victims were not ready to participate in grief groups early on. Family members were instrumental in encouraging others to participant in grief groups.

Community Resilience Project staff were invited to participate as counselors at a weekend-long grief camp for children who had lost parents due to 9/11 or other causes. Without exception, each staff member who provided services reported the camp was one of their most rewarding Project and grief-work experiences.

It is recommended that groups be facilitated by an experienced mental health professional, ideally with a cofacilitator, and be time-limited, with expectations defined at the outset.

Grief groups provide a supportive forum for people to discuss their reactions to loss. You have a group of individuals all of whom have something in common—which is having lost somebody dear to them. It doesn't have to be a family member; it can be a colleague or a friend…They might not know each other when the group begins. There were some people from New York that were also in our groups. The mutual support and trust that the group members build helps the process of renormalization of their lives as they discuss trying to put things back together again. The children have groups of their own, and they're able to express themselves in various creative ways, through artistic and other expressive methodologies. In all of these groups, feelings that would otherwise stay bottled up and might cause serious difficulties later on are brought to the surface in a timely manner. There's the feeling that I'm not alone in this. There are other people who are suffering too. They're still working. They're still getting by. Therefore, I can do it too. Align background

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

Mental Health Consultation[20]

Mental health professionals may be brought into decision-making and planning teams to advise public officials and community leaders about mental health issues. Public officials may seek mental health consultation on a variety of issues, such as mental health support, leave for rescue and recovery workers, and rituals or memorials for honoring the dead. To function effectively in this consulting role, disaster mental health workers must be well versed in emergency and criminal response protocols as well as the responding agencies' roles and priorities.

[20] Ibid.

Death Notification[21]

Mental health professionals may have an immediate support role with bereaved families and loved ones during and after a formal death notification. Mental health professionals typically do not deliver the death notification but rather accompany the persons responsible for the notification. Mental health professionals may:

- Provide support and mental health consultation to the family receiving the news
- When requested, provide support and mental health consultation to those conducting the notifications
- Provide, to those responsible for the notification, information on specific cultural or ethnic customs regarding the expression of grief as well as rituals surrounding death and burial

Death Notification Procedure

Mothers Against Drunk Driving (MADD) developed a curriculum on compassionate death notification for professional counselors and victim advocates. The curriculum is summarized below:

1. The coroner or medical examiner is absolutely responsible for determining the identity of the deceased.
2. Notify in person. Do not call. Do not take any possessions of the victim to the notification. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.
3. Take someone with you (for example, an official who was at the scene, clergy, and someone who is experienced in dealing with shock and/or trained in CPR/medical emergency). Next of kin have been known to suffer heart attacks when notified. If a large group is to be notified, have a large team of notifiers.
4. Talk about your reactions to the death with your team member(s) before the notification to enable you to better focus on the family when you arrive.
5. Present credentials and ask to come in.
6. Sit down, ask them to sit down, and be sure you have the nearest next of kin (do not notify siblings before notifying parents or spouse). Never notify a child. Never use a child as a translator.
7. Use the victim's name... "Are you the parents of _____?"
8. Inform simply and directly with warmth and compassion.
9. Do not use expressions like "expired," "passed away," or "we've lost _____."
10. Sample script: "I'm afraid I have some very bad news for you." Pause a moment to allow them to "prepare." "[Name] has been involved in _____ and (s)he has died." Pause again. "I am so sorry." Adding your condolence is very important, because it expresses feelings rather than facts and invites them to express their own.
11. Continue to use the words "dead" or "died" through ongoing conversation. Continue to use the victim's name, not "body" or "the deceased."
12. Do not blame the victim in any way for what happened, even though he/she may have been fully or partially at fault.
13. Do not discount feelings, theirs or yours. Intense reactions are normal. Expect fight, flight, freezing, or other forms of regression. If someone goes into shock, have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.

[21] Ibid.

14. Join the survivors in their grief without being overwhelmed by it. Do not use clichés. Helpful remarks are simple, direct, validate, normalize, assure, empower, and express concern. *Examples:* "I am so sorry." "It's harder than people think." "Most people who have gone through this react similarly to what you are experiencing." "If I were in your situation, I'd feel very _____ too."
15. Answer all questions honestly (requires knowing the facts before you go). Do not give more detail than is asked for, but be honest in your answers.
16. Offer to make calls, arrange for child care, call clergy, relatives, employer. Provide them with a list of the calls you make, as they will have difficulty remembering what you have told them.
17. When a child is killed and one parent is at home, notify that parent, then offer to take them to notify the other parent.
18. Do not speak to the media without the family's permission.
19. If identification of the body is necessary, transport next of kin to and from the morgue, and help prepare them by giving a physical description of the morgue and telling them that [Name] will look pale because blood settles to the gravitational lowest point.
20. Do not leave survivors alone. Arrange for someone to come, and wait until they arrive before leaving.
21. When leaving, let the persons know you will check back the next day to see how they are doing and if there is anything else you can do for them.
22. Call and visit again the next day. If the family does not want you to come, spend some time on the phone and re-express willingness to answer all questions. They will probably have more questions than when they were first notified.
23. Ask the family if they are ready to receive [Name's] clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.
24. If there is anything positive to say about the last moments, share them now. Give assurances, such as "most people who are severely injured do not remember the direct assault and do not feel pain for some time." Do not say, "s(he) did not know what hit them" unless you are absolutely sure.
25. Let the survivor(s) know you care. The most beloved professionals and other first responders are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.
26. Know exactly how to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.
27. Debrief your own personal reactions with caring and qualified disaster mental health personnel on a frequent and regular basis. Do not try to carry the emotional pain all by yourself, and do not let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

Summary

The real purpose behind a terrorist event is to create fear within the community. Providing good mental health services to survivors of a terrorist event requires a thorough understanding of common and more problematic reactions to such events. In addition to responding to the post-traumatic reactions, mental health workers may also be addressing ongoing fear. Service decisions must be guided by the key principles of disaster mental health intervention. The list of intervention approaches is provided in this module to help mental health providers understand the range of services that may be appropriate following a terrorist event. Ultimately, it will be up to each mental health service provider to learn from this guidance and, in the event of a terrorist attack, to use his/her experience and professional intuition to make the best decisions.

Additional Resources

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, http://www.mentalhealth.org/cmhs/.

DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Center for Mental Health Services. (Unpublished). Design and implementation of disaster mental health services: A handbook for mental health professionals. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Israel Trauma Center for Victims of Terror and War, http://www.natal.org.il.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs, http://www.ncptsd.org/publications/disaster/index.html.

MODULE 4: ADDRESSING THE UNIQUE NEEDS OF DIFFERENT POPULATIONS

> *The bottom line is that it was more than the attack on the World Trade Center. It happened here too, and not just to a military building, but to all the people who live and work in Northern Virginia. We need to grieve, to feel angry, and somehow, at the same time, to get on with our lives.*
>
> ——Virginia Governor Mark R. Warner

A mental health response to terrorism needs to reach out to the entire impacted community. In order to develop an all-inclusive outreach program, disaster mental health workers need to understand the demographic and cultural makeup of the community and its mental health implications. Certain cultural or ethnic groups may be affected uniquely by terrorist events. Some groups may experience backlash if the community associates them with the perpetrators of the terrorist event. Some groups, including immigrants, foreign students, and persons visiting from other countries may experience additional anxiety because of fear of deportation. A terrorist event may also lead to retraumatization among some refugees who experienced trauma in their native countries.

This module will help you assess and increase your cultural understanding of different groups and how to involve community gatekeepers in the disaster mental health response. It will show you how to identify the communities that are in need of services and resources, looking at factors such as level of exposure to an event and group-specific vulnerabilities that may be triggered. The module provides suggestions on how to customize mental health interventions to the unique needs of different groups based on culture/ethnicity, rural residence, age, disability, economic status, profession, and gender.

After completing this module, the learner will be able to:

- Assess and improve cultural understanding
- Work with community gatekeepers to enhance disaster mental health services and resources
- Increase access to and understanding of different populations

Looking Inward Before Looking Outward

Self-awareness about how well we understand groups of people who are different from ourselves is critical to our ability to serve them effectively. Before making contact with victims and survivors, it is recommended that disaster mental health workers take stock of their "cultural understanding" of the various groups that are affected by the disaster and that make up the communities in the area. How well understood and appreciated are these groups of people? How well can disaster mental health services address their beliefs and behaviors?

It is not uncommon for people, including disaster mental health workers, to:

- Inadvertently hold generalized beliefs about how some groups (such as age groups, genders, or racial/ethnic groups) react in crisis situations
- Feel more comfortable with groups that are more like themselves
- Soften professional boundaries in times of community crisis

Being aware of these tendencies can help the disaster mental health workers ensure that they provide the best possible services to communities in need.

The checklist in Table 4–1 will help evaluate behaviors that lead to effective interactions with these different populations:

Table 4–1. Checklist for Evaluating Cultural Competency[22]

Goal	How To Achieve It
Recognize the role of cultural beliefs and help-seeking behaviors.	_____ Recognize that the ability of the mental health worker to understand and respect survivors' cultural beliefs, language, and interpersonal style may help survivors to recover from traumatic experiences. _____ Talk with survivors about specific beliefs and customs that direct help-seeking behaviors and foster healing for them. _____ Understand the importance of issues such as space, time, and environmental control within different groups.
Understand natural support networks and healing practices.	_____ Recognize that, for groups centered around family and community, outreach that focuses only on the individual and that does not consider natural support networks might not be effective. _____ Find out who is important in survivors' lives by listening to how they describe their home, family, and community. _____ Be aware that different populations have different beliefs about what causes trauma and what leads to healing. _____ Help survivors to reestablish rituals and plan culturally appropriate commemorations.

[22] Adapted from Athey, J. (2003). Developing cultural competence in disaster mental health programs: Guiding principles and recommendations. (DHHS Publication No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Goal	How To Achieve It
Implement culturally competent outreach strategies.	_____ Recognize cultural differences related to accessing and communicating with different groups. Compose a community profile documenting these differences, which may include refugee status, income level, and literacy level. _____ Consult community gatekeepers to determine the best outreach strategies for specific populations. _____ Recruit mental health workers who reflect the demographic characteristics of the affected community. If workers from the community are not available, recruit others with similar backgrounds and language skills.
Ensure that outreach services are accessible, appropriate, and equitable.	_____ Recognize that different groups might be hesitant to use your services because of distrust of government and mental health stigmas. _____ Address concerns related to groups (e.g., refugees) who have suffered political oppression and are wary of government assistance. _____ Work to eliminate barriers to service such as language differences, mental health stigmas, and physical disabilities. _____ Establish a plan for preparing culturally appropriate materials and services, such as brochures in languages other than English and information sessions for people who are deaf or hard of hearing. _____Use existing community resources (e.g., faith communities, local radio programs) to disseminate messages.
Assess and evaluate the program's level of cultural competence.	_____ Continually evaluate the program to determine how to improve the planning and delivery of culturally competent services. _____ Involve community gatekeepers in the program evaluation.

Teaming To Increase Access and Provide Better Services

One important strategy to effectively reach affected communities is to partner with organizations that represent specific communities in need of disaster mental health services. These organizations can provide both access into and a better understanding of their communities.

I was very proud of what we did in our community to respond to 9/11. The decision was made early on that, when we did our outreach crisis counseling program in our community, we would contract with organizations that were ethnically based or ethnically connected, because we knew that a large majority of the people who would be impacted by 9/11 would be members of minority groups. So we contracted with ethnic organizations to provide outreach counselors and their supervisors. We then provided training to them. The training was provided intensively in the beginning and then on an ongoing basis over the life of our project. So, by using organizations that had an affiliation with a particular ethnic group, the project had improved credibility in the target communities and, thus, penetrated the communities much more quickly than if we had had to establish our credibility.

Donna M. Foster, M.S.W.
Project Director, Fairfax County
Community Resilience Project

Community gatekeepers can also help gain survivors' trust and acceptance. The Patriot Act has increased fears that people's immigration status may be reviewed and result in their deportation. Therefore, they may be less likely to seek help. An endorsement of the disaster mental health worker by a trusted member in their community, however, may help provide credibility and the access necessary to be accepted and better able to provide needed services.

Once the gatekeepers are identified, it is important to explain how disaster mental health workers can help them during difficult times. It is also important to demonstrate respect for how their organizations operate and explain how disaster mental health services can help their community.

Community-based organizations include:

- Civic and volunteer groups
- Neighborhood associations and watch-groups
- Recreational and social clubs
- Religious organizations
- Professional or business groups
- Interfaith groups
- Mutual aid societies
- Nonprofit advocacy organizations
- Health care and social service networks

It is also helpful to identify mental health professionals from these groups and to recruit people interested in becoming paraprofessionals to assist with outreach and intervention efforts. They can be powerful peer counselors and bring major benefits to your program by gaining access to different populations, providing appropriate language skills, and lending credibility and trust.

Other community gatekeepers may be found in religious organizations, schools, and neighborhoods and include religious leaders, teachers, coaches, local business owners, librarians, historians, and long-time residents.

Community cohesion includes learning about each other—immigrants knowing more about area programs and services, and natural-born citizens learning about the cultures of immigrants. We worked to promote community cohesion by holding community forums and by reaching out to individuals and groups to help struggling immigrants access the services that were available to them. The immigrants on our outreach team acted as goodwill ambassadors to those they came into contact with, sharing their culture and experience.

Deborah Warren, L.C.S.W., D.C.S.W.
Project Director, Alexandria
Community Resilience Project

Community gatekeepers can help:

- Assess needs and identify communication and access issues
- Identify needs in the community
- Develop strategies for responding to specific groups
- Organize support groups and meetings
- Translate materials
- Distribute materials
- Translate for survivors who do not speak English or who use sign language

Community gatekeepers also can train mental health disaster workers and give suggestions on how group members seek help. Ongoing training sessions might focus on using strengths, such as strong family ties and previous recovery from crisis, to build resilience. Other important training topics gatekeepers may assist with are:

- Cultural competence
- Linguistics
- Literacy and education levels
- Communication and access issues
- Experience with terrorism or other disasters
- Family and community values

- Support systems
- Experience with public assistance agencies or other "outside" help
- Mental health stigmas

Identifying Communities in Need of Services and Resources

Assessing the potential mental health needs of different groups following a terrorist event includes a review of the three elements described below. High levels of any of these indicate a need for monitoring and possible intervention.

- **Nature and severity of the event.** This can be assessed several ways. One obvious way is by looking at the number of casualties and the amount of property damage that result from the event. However, the level of terror and fear spread among communities and individuals may not necessarily coincide with casualties or property damage. The sniper attacks that took place in the Washington, DC, metropolitan area and Virginia in the Fall of 2002 claimed a much smaller number of lives than the terrorist attacks of September 11, 2001; however, some people in the region felt that terror that stemmed from the attacks affected more of the general population because the sniper was "on the loose" for many weeks. For more information on assessing nature and severity, see Module 2.

- **Level of exposure/proximity to the event.** Terrorism affects the entire community, but it most severely affects those who experience the event directly or those who have previously been traumatized by a terrorist-related event. For more information on the Population Exposure Model and the "ripple effect," see Module 2.

- **Group-specific vulnerabilities that could be aggravated by the event.** These are further explained in the following sections.

A comprehensive needs assessment considers language and communication barriers and access issues of different populations. Persons who do not speak English, are deaf or hard of hearing, or are illiterate, for example, are at a significant disadvantage if services are not easily accessible to them. Someone from a cultural group that considers physical contact with strangers to be inappropriate will have a negative reaction if a disaster mental health worker touches their arm as a sympathetic gesture. Someone who only seeks advice from his/her religious leader might not listen to "outside" help. Understanding these potential barriers will lead to better intervention/service provision decision-making.

It is also important to know about individual vulnerabilities that affect how someone reacts to terrorism. The National Center for Post-Traumatic Stress Disorder advises, "Some individuals have a higher than typical risk for severe stress symptoms and lasting PTSD, including those with a history of:

- Exposure to other traumas (such as severe accidents, abuse, assault, combat, rescue work)
- Chronic medical illness or psychological disorders

- Chronic poverty, homelessness, unemployment, or discrimination
- Recent or subsequent major life stressors or emotional strain (such as single parenting)."[23]

Community gatekeepers can help put together a community profile to determine potential vulnerabilities and other factors that might influence the mental health of their communities. They can work with community gatekeepers to research and collect information to gain insight into a particular community with regard to factors such as:

The challenges we saw had to do with miscommunication, not understanding different cultures—the way different people perceive things, their different religious points of view, where they had come from. Many people think that their way of thinking is the only way of thinking, but there are other views and values that need to be recognized and understood.

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- Race/ethnicity
- Refugee and immigrant status
- Age
- Gender
- Religion
- Attitudes (including mental health stigmas)
- Lifestyles and customs
- Interests
- Values
- Beliefs
- Physical disability status
- Mental/emotional disability status
- Family frameworks (e.g., single-parent, blended-family, or multiple-family households)
- Income levels
- Professions and unemployment rate
- Languages and dialects
- Education and literacy levels

[23] National Center for Post-Traumatic Stress Disorder. Helping Survivors in the Wake of a Disaster—A National Center for PTSD Factsheet. Retrieved at http://www.ncptsd.org/facts/disasters/fs_helping_survivors.html.

Demographic information is also available from the U.S. Census Bureau and local government agencies.

Providing Services to Different Populations

The face of the United States is constantly changing. Suburban sprawl, migration, and changing employment opportunities have created a more transient population and shifting demographics. To anticipate how these changes affect disaster mental health services, it is useful to learn about the people within the affected community.

You have to listen to the concerns of those communities, and you need to be respectful. It is important to listen to what they're saying, what their needs are, and how they are distinguished from the "majority" society. Of course, the project cannot ignore the majority society. But, in order to reach these communities…you need to listen to them so that they feel that their needs are being fairly addressed by the services that you are delivering.

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This section:

- Describes the populations that emerged as having unique needs during the Northern Virginia experience with terrorism
- Identifies factors that may affect mental health service provisions
- Provides recommendations for providing mental health services

If another terrorist event takes place, other populations in addition to those described here may be uniquely affected and will be targeted for services.

Culture/Ethnicity

Among many other things, terrorist events can heighten a community's sense of fear, suspicion, and vigilance. Some cultural/ethnic groups may experience backlash if the community associates them with the perpetrators of the terrorist event. Post-9/11, many Muslim Americans and Korean Americans in Northern Virginia were the victims of backlash. Backlash can happen anywhere, anytime—as people work, go to school, shop, or try to cross the street—as the examples below from Fairfax County illustrate.

- Several people, especially women wearing the hijab (scarf for head cover), reported being almost hit by a car while walking.
- Two mosques were vandalized in 6 months—one was painted with swastikas and hate messages; the other had a school bus burned while parked on the mosque property.
- Afghani taxi drivers reported being regularly insulted by their customers.
- One Muslim woman, working in a retail establishment, was accosted by a customer and told "Go home!"

- One African-American Muslim child was hit at school by a classmate who, when questioned by his teacher as to why he hit the Muslim child, told the teacher he/she hit the Muslim child because he was "Afghani."

- A male, Muslim apartment owner, who forgot his key, was not let in by another resident because "he might be a terrorist"; the female resident insisted on calling the police.

- The tensions between North Korean and the U.S. over nuclear capability have created a new type of anxiety similar to that which immigrants from Muslim countries have experienced. Vans that belonged to the Korean Crisis Counseling teams were vandalized twice while parked at a church. The vans belonging to the church were not touched.

Post-event law enforcement activities also can add to the fear that certain cultural/ethnic groups experience. See the examples below.

- In March 2002, armed federal agents who were looking for terrorist ties in Northern Virginia raided about 20 homes and businesses owned by Muslims. Although no one was indicted, the cases generated a constant fear of more such raids.

- The Immigration and Naturalization Service (INS) started to register all Muslim non-U.S. citizen males as a part of the terrorist tracking. Some who went to register were arrested on minor visa violations and deported.

- FBI and other federal agents visited mosques and questioned people about their friends and other members of the congregation.

- Hundreds of Iraqis and Muslims were detained for "questioning" for long periods after the war in Iraq started, creating fear in the Muslim community.

While providing services to members of cultural/ethnic groups, it is important for disaster mental health workers to understand that members of the same group may hold different political, cultural, and religious views from each other. Therefore, it is critical that disaster mental health workers not align themselves with—or distinguish themselves from—a particular view or tradition. In other words, they need to stay neutral.

The Middle Eastern Muslim population is within itself a very diverse group of people, and they don't necessarily collaborate with each other or with the government very often. And so when we set up that contract, it was a real challenge to get four different mosques to develop programs, to identify people with the right kinds of skills, to represent their ethnicities and their different factions within those ethnicities on the teams. This was important so that the entire Middle Eastern Muslim community felt represented and was approached in terms of the services that they needed.

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Community Resilience Project

Recent Immigrants

Recent immigration to the United States is another major factor that surfaced throughout Northern Virginia's response efforts. Uprooting one's life and moving to another country is stressful. Not only do immigrants need to adapt to a new language, but they are also assimilating to a new culture, which leaves them more vulnerable during a crisis. This vulnerability may be intensified by the following:

- Leaving behind social support systems (e.g., family, friends) and trying to establish new ones
- Securing employment and financial stability
- Changing family member roles (e.g., adults could develop an unfamiliar dependency on children who learn English quickly)
- Adapting to a new culture and environment

Refugee Community

The hardships of refugee communities lead to the potential for retraumatization as well. In fleeing their native countries because of social or political disorder, many refugees have suffered loss of loved ones and possessions. A terrorist event could remind them of past pain and lead to retraumatization—or a show of resilience that comes from already having experience with difficult situations. It is important to acknowledge the trauma in their history and validate the insight and strength of refugees. Some refugees feel betrayed by their native country and are cautious of building friendships in their new homelands, except with a select few. This distrust—especially in refugees who suffered from political oppression—extends to police officers, the military, social service workers, and government employees, making some refugees hesitant to seek out and accept help.

Below are some points to consider when working with refugees.

- Respect their views about assistance agencies and staff members.
- Team with appropriate community gatekeepers.
- Approach refugees lightly, displaying courtesy and cultural competence.
- Take time to earn the confidence of refugees.

It is very important to respect and address different linguistic needs. Materials should be translated into the languages that are spoken in the community. Virginia is home to people of many native countries, religions, and ethnicities. For example, in Arlington County alone, more than 60 different languages are spoken by students enrolled in the Limited English Proficiency

program.[24] More than 100 languages are spoken at one school in Fairfax County. Services should be available in the most common languages spoken by disaster survivors, including American Sign Language, and interpreters should be identified for as many other languages as possible. Staff should have strong ties to the communities they will be serving. Sometimes there may be a need to use an outside interpreter. The following box provides some guidelines for working with interpreters.

Guidelines for Using Interpreters[25]

- Determine survivors' language and dialect needs first.
- Hire certified interpreters who share a community's racial/ethnic background. If this is not possible, give interpreters training in cultural competence.*
- Monitor signs of the interpreter's potential biases and comfort level with topics. Allow time for the interpreter and survivor to establish rapport and trust through informal conversation.
- Use a consistent style of interpretation that is easy to follow. For example, the survivor speaks and the interpreter translates for the mental health worker, or the mental health worker speaks and the interpreter translates for the survivor.
- Allow at least twice as much time for interactions to take place.
- Avoid using a survivor's family members—particularly, children—and friends as interpreters. Survivors could feel uncomfortable or ashamed to discuss their concerns through them.

** To the extent possible, the disaster mental health worker should prepare the interpreter on providing services to a person of that particular community.*

Other issues that may vary based on cultural/ethnic differences are feelings about time and destiny. Some groups and individuals may consider being on time extremely important, while others may be more flexible with schedules. Be aware of such attitudes, and respect these differences by not imposing rigid timetables or by being late to appointments.

People who believe their recovery is in the hands of an external force—luck, fate, or divine intervention—might not understand initially how a disaster mental health worker can help them. On the other hand, those who believe they have the power to heal themselves may be more receptive to crisis counseling services.

Children

Children process information, and experience and express emotions differently than adults. Disasters, violence victimization, and sudden deaths of loved ones are experienced within the context of a child's psychological development, life and family situation, and critical caretaking relationships.[26] Terrifying events can cause overwhelming and unfamiliar physical reactions and

[24] Federation for American Immigration Reform. Virginia: Social policy issues. Accessed 2003 at the Federation for American Immigration Reform Web site: http://www.fairus.org/html/042vasoc.htm.
[25] Adapted from Athey, J. (2003). Developing cultural competence in disaster mental health programs: Guiding principles and recommendations. (DHHS Publication No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[26] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

emotions that can be traumatizing to children (see Module 3 for lists of normal reactions to terrorist events in children).

Children have a difficult time deciding what is fact and what is fantasy, which leads to fear and confusion. In trying to make sense of what has happened, children often blame themselves for causing or worsening the incident, which can lead to feelings of guilt and shame.

Very young children depend on a stable environment and reliable people to take care of them. As children become older, they may try to understand why the event happened and what will happen next. Family, significant adults, pets, playmates, school, and neighborhoods are important features in a child's world. When a terrorist event takes place in a community, many of the significant features may be disrupted or destroyed.

Eventually, over time and with a lot of perseverance, we developed very good relationships with some key people within the community. We developed a very good network with libraries, for example, where they were actually referring people to us. People were going to the libraries saying that their children were really upset about 9/11 or the sniper, and they wanted books. Since the libraries didn't have any relevant books, they would refer them to us. Over time, we worked with the libraries to develop their library system so they did have the books, magazines, and handouts available so that they could help people in an ongoing effort.

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The sniper attacks that occurred in Virginia, Maryland, and Washington, DC, greatly affected school staff and school children. Children were locked down in schools (i.e., not permitted to leave the school building during school hours) for weeks. Police officers were stationed at the schools and, in some communities, they escorted buses. Homecomings and sports events were cancelled. Opportunities were lost that can never be regained.

Consider the following when assessing a child's potential for trauma and planning a mental health response:

- Direct threat to life and physical safety
- Degree of cruelty by violence and weapons
- Seeing graphic acts of death and injury
- Hearing cries for help
- The event's randomness and length
- Separation from family members, friends, and caregivers
- Family atmosphere
- Parental resilience
- Exposure to media coverage
- Economic hardship

Keep in mind that children who have witnessed the disaster only via the media can also experience stress reactions.

Focus on helping children understand the terrorist event, regain a sense of safety, and resume activities. Below are suggestions to help them cope.

- Answer questions about what happened or what could happen honestly and at a level the child will understand, without dwelling on scary details.
- Openly admit to children that you cannot answer all questions.
- Encourage children to express emotions by talking, drawing, or painting.
- Encourage children to express their feelings to adults, including teachers and parents.
- Allow silences.
- Encourage children to participate in recreational activities.
- Help children understand that there are no "bad" emotions.

Also, advise parents, caretakers, and teachers to follow the advice below.

- Stay calm and take care of themselves.
- Do not allow the terrorist event to dominate family or classroom time indefinitely.
- Put together emergency plans and include children in the process.
- Give children lots of love and extra attention.
- Validate children's fears and reassure them verbally, telling them the adults will do everything possible to protect them.
- Watch news coverage with children so the adults can answer questions and give support.
- Limit children's viewing of news coverage, as it can further traumatize children and/or enhance their fears/nightmares. Consider the age and maturity of the child when deciding how much to limit.
- Maintain routine and regular discipline.

One-on-one support from a mental health worker and extensive intervention might be needed for children who show instant signs of trauma or more problematic reactions. Such children may appear disoriented, display atypical behavior, or be in shock. Appropriate immediate responses might be:

- Physical comforting, including snacks and blankets
- Rest

- Repeated assurance of safety
- Honest and age-appropriate answers to questions
- Creative materials so they can draw and play
- Opportunity to talk about their feelings

The table below lists age-specific symptoms and intervention options.

Table 4–2. Children's Reactions to Trauma and Suggestions for Intervention[27]

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1–5	• Clinging to parents or familiar adults • Helplessness and passive behavior • Resumption of bed-wetting or thumb sucking • Fear of the dark • Avoidance of sleeping alone • Increased crying	• Loss of appetite • Stomach aches • Nausea • Sleep problems, nightmares • Speech difficulties	• Anxiety • Generalized fear • Irritability • Angry outbursts • Sadness • Withdrawal	• Give verbal reassurance and physical comfort • Provide comforting bedtime routines • Help with labels for emotions • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Demystify reminders • Encourage expression regarding losses (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

[27] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
6–11	• Decline in school performance • School avoidance • Aggressive behavior at home or school • Hyperactive or silly behavior • Whining, clinging, acting like a younger child • Increased competition with younger siblings for parents' attention • Traumatic play and reenactments	• Change in appetite • Headaches • Stomach aches • Sleep disturbances, nightmares • Somatic complaints	• Fear of feelings • Withdrawal from friends, familiar activities • Reminders trigger fears • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self-blame • Guilt	• Give additional attention and consideration • Relax expectations of performance at home and at school temporarily • Set gentle but firm limits for acting out behavior • Provide structured but undemanding home chores and rehabilitation activities • Encourage verbal and play expression of thoughts and feelings • Listen to child's repeated retelling of traumatic event • Clarify child's distortions and misconceptions • Identify and assist with reminders • Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, and identifying at-risk children

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
12–18	• Decline in academic performance • Rebellion at home or school • Decline in previous responsible behavior • Agitation or decrease in energy level, apathy • Delinquent behavior • Risk-taking behavior • Social withdrawal • Abrupt shifts in relationships	• Appetite changes • Headaches • Gastrointestinal problems • Skin eruptions • Complaints of vague aches and pains • Sleep disorder	• Loss of interest in peer social activities, hobbies, recreation • Sadness or depression • Anxiety and fearfulness about safety • Resistance to authority • Feelings of inadequacy and helplessness • Guilt, self-blame, shame, and self consciousness • Desire for revenge	• Give additional attention and consideration • Relax expectations of performance at home and school temporarily • Encourage discussion of experience of trauma with peers, significant adults • Avoid insistence on discussion of feeling with parents • Address impulse to recklessness • Link behavior and feelings to event • Encourage resumption of social activities, athletics, clubs, etc. • Encourage participation in community activities and school events • Develop support programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens

Older Adults[28]

Older adults may in some ways be uniquely resilient to the grief and trauma of terrorist events. The wisdom and experience accrued over a lifetime can provide tools to help cope with loss, changes, and painful emotions. As older adults become more physically frail or have significant health problems, however, their reactions to terrorist events can be greatly affected by their physical needs. When an older person is already feeling vulnerable due to changes in health, mobility, and cognitive abilities, the feelings of powerlessness and vulnerability associated with a terrorist event can be overwhelming. Sudden evacuations from nursing or residential facilities can be disorienting and confusing. Sensory impairment may cause older adults to be unresponsive to offers of help. Some could reject mental health help because of the fear of being institutionalized, while others might have trouble filling out assistance forms. Below are other ways that older adults could be affected.

- Overwhelming grief after losing grandchildren.
- Fear after losing children who were their primary caretakers.
- Distresses over having to step in to care for a child whose parents have died. This reaction is intensified as they worry about changing their lifestyle and making sure there is enough money to care for an extra person in their household.
- Memories of combat that could be stirred up in war veterans who have seen a disaster site.

Loudoun County Experience With Older Adults

It was interesting to observe older adults after 9/11. With the insight of people who have lived many years, have seen many things, and had personal trials and hardships, they were the first to "move on." The honesty with which they chose to continue with their lives means, ultimately, that to be a survivor it is important to put things in perspective. This population was able to do this very effectively.

My personal story in relation to the Community Resilience Project (CRP) is a little different from those of others on my team. I was already an employee of Loudoun County with the Department of Parks and Recreation with the Area Agency on Aging. Since 9/11, I have had the pleasure of working with many older adults who were already "plugged in" to the system. A person dealing with this population soon realizes how important trust is. I was already "in." I was able to respond to their concerns, and they did not have to be concerned about talking to a "stranger." They knew very well who I was, and we already shared interest in and love for each other.

Services for older adults need to be coordinated with senior groups, caretakers, and health care providers. When assessing the needs of older adults, consider the following:

- Trauma and loss
- Psychological and physical stress
- Medical and health status, including their senses, memory, and mobility

[28] Adapted from DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners, and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- Cultural background, including past trauma and loss
- Availability and proximity of support systems
- Living situation, including assistive features of their homes, such as shower rails and emergency phone numbers on speed-dial
- Priority of concerns and needs

The table below lists symptoms that older adults may exhibit, as well as intervention options for providing services to them.

Table 4–3. Reactions to Trauma and Suggestions for Interventions with Older Adults[29]

Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
• Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems	• Worsening of chronic illnesses • Sleep disorders • Memory problems • Somatic symptoms • More susceptible to hypo- and hyperthermia • Physical and sensory limitations (sight, hearing) interfere with recovery	• Overwhelmed and shutting down • Depression • Despair about losses • Apathy • Confusion, disorientation • Suspicion • Agitation, anger • Fears of institutionalization • Anxiety with unfamiliar surroundings • Embarrassment about receiving "handouts"	• Provide strong and persistent verbal reassurance • Provide orienting information • Ensure that physical needs are addressed (water, food, warmth) • Use multiple assessment methods, as problems may be underreported • Assist with reconnecting with family and support systems • Assist in obtaining medical and financial assistance • Encourage discussion of traumatic experience, losses, and expression of emotions

Rural Communities[30]

Reactions to terrorism and willingness to accept mental health help can also be linked to the surroundings in which we live. The rural culture differs from urban areas in the seasonal effect of the work, in accessibility, and in free time available. Besides the normal phases people experience after a disaster, there are other timing considerations. In a farming area, times of ground preparation, seeding, and harvest typically offer reduced accessibility of outreach workers to the affected population. Consideration should also be given to the differing roles and corresponding

[29] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

[30] Adapted from Jackson, G., Cook, C. (1999). Disaster mental health: Crisis counseling programs for the rural community. (DHHS Publication No. SMA 99-3378). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

stressors that apply to men, women, and children in the area. Switching the focus of service delivery to coincide with stress levels and availability may help the program's efficacy overall.

Some ethnic or cultural groups may not be receptive to services, and gaining their trust may be a challenge. Establishing key community contacts and matching outreach workers to the communities they are trained to serve can create opportunities for service. Sensitivity to language, traditions, and cultural values is vital.

Even if a rural area appears to be homogeneous, ethnic differences can exist. Differences might exist in educational background, religious beliefs, country versus town dwellers, farmers versus ranchers, people who live by the river versus those who do not, etc. Some small communities are as divided by income, education, and religion as are the most diverse inner-city neighborhoods.

I feel that it is a lot harder to get into the rural areas; in many ways it's like a subculture. They tend to take care of their own. They tend to think of themselves as very independent, self-reliant, and very resilient. They often don't want outside help, especially "government" help. So, it was very hard to gain their trust if you didn't have an "in" into that community. Perseverance was the key. We sent people over and over again. We did 4H fairs. We did school activities. We were at the libraries and at the churches, both of which were key in getting into the rural areas.

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A sense of independence and self-determination is a hallmark of the residents in rural areas. Many rural residents tend to view themselves and their communities as possessing a higher quality of life and a more realistic, down-to-earth lifestyle than their urban counterparts. Family, close friendships, and a highly developed sense of community combine to create a sense of self-sufficiency that persists even in the most difficult circumstances. Frequently, in times of disaster, these values are demonstrated as family, friends, and community members provide mutual support, shelter, and care to one another.

Rural people may not actively seek help. Residents of rural areas often are not aware of services available or how to access them. They may think the process is too cumbersome or intrusive. It is also common for a farmer or small business owner not to apply for assistance due to pride, an underestimation of loss, or a belief that others are more in need of help. If the decision is made to apply for assistance, the process may be particularly difficult for someone unaccustomed to admitting need and seeking assistance. Asking for help is very difficult when the cultural expectation is competence and self-reliance.

Receiving any form of mental health services may be seen as a negative reflection on a person's character or family life. This pervasive attitude is even more prevalent in rural communities. Disaster survivors may have a negative impression of mental health services and thus would be offended if made to believe they needed such support. Having fewer mental health resources in a community and a self-reliant cultural bias, people in rural communities may lack an understanding of the need and use for mental health services. Therefore, it is recommended that programming and project identity avoid the use of mental health jargon and frame services in terms of disaster survivors deserving counseling services.

In rural America, traditional organized religion is often a powerful presence. The religious traditions of individuals, families, and communities have become the primary expression of their sense of right and wrong, moral and immoral, good and bad. These traditions provide the structure and language by which the rural population evaluates the world and makes decisions. Such a personal belief system can aid greatly in the disaster recovery process. In rural communities, faith-based communities provide a valuable resource for finding and serving literally hundreds of people. Collectively, the community faith-based centers represent a cross-section of the local social structure with respect to income, education, vocations, and community involvement.

When providing services to rural community members, consider the points below.

- Respect their reluctance to discuss mental health issues.
- Team with appropriate community gatekeepers. Often, these are individuals from families that are respected in the community.
- Approach them from a wellness perspective.
- Use messages of resilience and encourage them to stay positive.
- Take time to earn their trust.

Rural communities that are growing and transitioning to a more urban environment may have some special needs, too. The CRP, for example, found that some residents who were new to communities were in some ways more open to discussing their mental health needs than their more established counterparts, but they were likely to experience vulnerabilities, such as a lack of established support systems and animosity against them by longtime residents.

First Responders

Emergency workers—police, rescue squads, firefighters—are often the first ones on the scene and the last ones out. Long hours, harsh working conditions, and a close-up view of death and destruction leave them vulnerable to intense trauma reactions.

Working with Firefighters and Paramedics

I have worked with several of the firefighters and paramedics who responded to the Pentagon on September 11 and were part of the recovery efforts. In the first stages, I did ride-alongs at four stations to gain trust, educate them about the program, etc. I went on the "Fireline" show for the department in November 2001, and again in November 2002, to discuss the Community Resilience Program and how persons would recognize symptoms of stress.

By December 2001, I had spoken with many of those who responded, and I even had some "dinner-time firehouse discussions." Others would seek me out individually, just to express difficulties sleeping or images coming into their minds. The wife of a paramedic who was part of the recovery met with me several times during the first 6 months because she was having nightmares and was crying when the news came on. Her husband also stayed on my "watch" because, although he is a "tough guy," he was having a stress reaction of increased irritability, and some family problems had come up that made it more challenging.

I have continued occasional ride-alongs and events so that these people remain familiar with me. Often, different fire or paramedic supervisors will contact me saying they have a concern and will ask me to come out to the station.

Specifically, first responders are affected by:[31]

- Scale of an event
- Randomness of an event
- Failure to save people immediately or at all
- Exposure to carnage
- Identifying with survivors
- Direct threat to life or of harm
- Erratic work schedules and environments
- Fatigue
- How clearly they understand their role
- How much training, experience, and equipment they have to do their job
- Authority issues within their organizations
- Jurisdiction issues with other agencies
- Cultural clashes with communities or other workers
- How they are perceived by a community

[31] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

The most severe reactions arise when first responders:

- Are overexposed to the dead and dying
- Deal with corpse removal, especially of children
- Experience extreme fatigue and physical exhaustion
- Are exposed to toxic agents like chemical or radioactive material

Personal situations, such as problems at home or fantasies about being heroes, also shape first responders' experience with terrorism.

In particular, lack of social support could leave some first responders vulnerable. Police officers, for example, often work solo or with one partner. The solitary nature of their business gives them few chances to build supportive relationships—the closest bond they have might be with their partner. Should something happen to their partner, it could be devastating.

Firefighters treat each other more like family. They share meals together and sometimes even live in the same house. Having more people to talk to, however, does not mean they will share their feelings. Like law enforcement workers, many firefighters worry about being labeled "unfit for duty" if they open up about being scared or anxious.

So when do first responders need the help of disaster mental health workers?

Watch for these stress reactions: [32]

- Shock
- Impaired concentration
- Irritability and anger
- Confusion and disbelief
- Distorted perception of situations
- Terror and despair
- Intrusive thoughts
- Guilt
- Decreased self-esteem
- Feeling powerless and helpless
- Grief
- Disassociation with individuals and activities

[32] Ibid.

While these reactions are common, in the long term they could lead to depression, chronic anxiety, or retraumatization. They could also cause or worsen existing problems at work, with families, or with substance abuse.

Stress prevention and management needs to be incorporated into training by employers. If first responders are reluctant to open up in job-sponsored forums, however, they may consider getting help from outside their working world. This could include a community program or mental health services provided by phone or online. They may respond more positively in an environment that recognizes their contributions and respects their silences. It is important that intervention should be individual, voluntary, and at a pace with which first responders are comfortable. The table below offers immediate and longer term suggestions you can give first responders to help manage their workload, maintain a balanced lifestyle, reduce stress, and conduct a self-assessment for trauma reactions.

Table 4–4. Approaches for Stress Prevention and Management for First Responders[33]

Dimension	Immediate Response	Longer Term Response
Management of workload	• Clarifying with immediate on-site supervisor regarding task priority levels and work plan • Recognizing that "not having enough to do" or "waiting" is an expected part of crisis mental health response • Delegating existing "regular" workload so that workers are not attempting disaster response and their usual job	• Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") • Conducting periodic review of program goals and activities to meet stated goals • Conducting periodic review to determine feasibility of program scope with the human resources available
Balanced lifestyle	• Ensuring nutritional eating and hydration; avoiding excessive junk food, caffeine, alcohol, or tobacco • Getting adequate sleep and rest, especially on longer assignments • Engaging in physical exercise and gentle muscle stretching when possible • Maintaining contact and connection with primary social support	• Maintaining family and social connections away from program • Maintaining (or beginning) exercise, recreational activities, hobbies, or spiritual pursuits • Pursuing healthy nutritional habits • Discouraging overinvestment in work

[33] Adapted from DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Dimension	Immediate Response	Longer Term Response
Stress reduction strategies	• Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) • Using time off to "decompress" and "recharge batteries" (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times	• Using cognitive strategies (e.g., constructive self-talk, restructuring distortions) • Exploring relaxation techniques (e.g., yoga, meditation, guided imagery) • Pacing self between low- and high-stress activities, and between providing services alone and with support • Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions
Self-Awareness	• Recognizing and heeding early warning signs for stress reactions • Accepting that one may not be able to self-assess problematic stress reactions • Over-identifying with or feeling overwhelmed by survivors' and families' grief and trauma may result in avoiding discussing painful subjects • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995)	• Exploring motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) • Understanding when "helping" is not being helpful • Understanding differences between professional helping relationships and friendships • Examining personal prejudices and cultural stereotypes • Recognizing discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety, which interferes with the capacity to "be" with clients • Recognizing over-identification with survivors' frustration, anger, anguish, and hopelessness, resulting in loss of perspective and role • Recognizing when own disaster experience or personal history interferes with effectiveness • Being involved in opportunities for self-exploration, and addressing emotions evoked by disaster work

Military

During the 9/11 attack at the Pentagon, the military emerged as a major population that disaster mental health workers targeted for services. These workers had to consider the military's history and culture in dealing with crisis situations, as well as factors that create daily stress for members of the military and their families—such as war, deployments, dangerous field exercises, and constant moves that leave many far from their families and friends. A terrorist event and the resulting heightened security at military installations could increase their stress and anxiety, and lead to the need for intervention.

It is important to know that the military is a close-knit community with a history of responding as an organized unit. Training and working together closely for long periods of time creates a feeling of belonging and cohesion. Disaster mental health workers need to recognize and respect this system, and approach senior command personnel first. Establishing relationships with them and getting their approval early will be especially helpful in gaining access to the military.

In the military, mental health treatment is considered to be under heavy stigma. Whether it's myth or real, many military personnel believe that receiving mental health services can interfere in their career by going on their record, which in turn could potentially interfere with getting top-secret clearance. So it is very important that, when doing disaster work with the military community and the military establishment, we are mindful that it is not traditional mental health. It is not diagnosing people. Rather, it is helping people to understand that the reactions, not the symptoms that they are having, are natural actions to an unnatural situation. You can help them to understand that by encouraging them to participate in information sharing and seminars on stress management. You can get the word out that difficulty with sleeping or concentrating are transient reactions that most people have in this type of situation and, with a little bit of time, the reactions will probably go away.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

In addition to setting up general information sessions, senior leaders can provide insight into military life. Consider the points below when planning services for the military.

- Be aware of rank structures and military courtesies.
- Hold separate meetings for senior officers and junior enlisted military members.
- Help senior staff take care of the younger troops by providing services in accordance with the needs and parameters set by the commanding officer. As immediate supervisors, senior staff members provide an invaluable channel for reaching the troops.

It is also important to know how to help if deployments are ordered in the midst of crisis. Following 9/11, soldiers being sent to Afghanistan were more worried about the families they were leaving behind than themselves. Address their fears and let them know their families will be taken care of. Back home, partner with military chaplains and family support groups to provide services for families of deployed units.

It is helpful to start an open dialogue by having an outreach worker who is a former military member lead the disaster mental health team. This may make it easier for soldiers to open up and for disaster mental health workers to penetrate what could be a hard-charging, tough exterior. Being honest about limitations in understanding military culture and making services voluntary and confidential will enable this process.

Consider coordinating efforts with the military community's natural support systems. Military chaplains, for example, are an excellent resource and are often the first people on the scene. Others gatekeepers include:

- Rapid response teams comprising psychologists, psychiatrists, social workers, and chaplains

- Community services and assistance centers
- Family readiness groups
- Ombudsmen
- Spouses of senior enlisted staff
- Spouses of executive officers

Other Considerations

Terrorist disasters affect many different groups in different ways. It is important for the mental health response to assess which groups have been affected and how they have been affected. This section shares provides CRP's experience with other groups and illustrates how disaster mental health workers need to identify and provide appropriate services to each of these groups.

People with physical disabilities may feel extremely helpless if separated from caretakers or special equipment or assistance, such as wheelchairs, hearing aids, walking sticks, or seeing-eye dogs. As much as is possible, the specific physical needs of people with different sight, hearing, and mobility issues need to be met. Outreach materials, for example, can be produced with closed captioning or written in Braille. Also, interpreters can be used to help communicate in sign language.

Reaching the Deaf and Hard of Hearing

The CRP helped members of the deaf and hard of hearing community recover by providing group and individual crisis counseling using deaf and hard of hearing counselors. Ultimately, the goal was to connect service providers and train the trainers to provide psychological preparedness education to the deaf and hard of hearing community. The deaf and hard of hearing counselors also presented a workshop on psychological preparedness at the National Deaf and Hard of Hearing in the Government conference held at the National Institutes of Health. The presentation was standing room only and demonstrated the desire for such information in the deaf and hard of hearing community.

People with mental/emotional disabilities can feel especially terrified and confused when terrorism hits. Not fully understanding what happened can lead to additional trauma, which may require extra medication or hospitalization. When providing services, consider the points below.

- Recognize people may "rise to the occasion" with resilience.
- Tailor services to meet people's specific mental health needs.
- Watch closely for trauma reactions that are similar to symptoms of mental illness.
- Monitor people with PTSD who could react to triggers such as sirens and feelings of powerless that may remind them of past trauma.

Economically disadvantaged communities are underresourced in terms of economic assets. Often, social assets are worn down and strained prior to the event, making it more difficult for residents to draw on traditional social networks during and after an event. Protective factors are weak and in some cases nonexistent. Individuals from underresourced neighborhoods may also have a higher rate of exposure to trauma as a result of neighborhood violence, family dysfunction, and alcohol and substance abuse.

With the great diversity in our county—1 out of 5 people are not born in the United States—there's not only a great number of different ethnicities and races involved, but there's also a great deal of variation in terms of how long people have been here, how acculturated they are, and how they have acclimated to the American society's demands on them. Most of the recent immigrant populations are at a very early stage in terms of their economic development, and some of them were economically devastated by the economic downturn following the 9/11 attacks. There was a very disproportionate amount of negative effects on people who were very isolated, very fearful, very scared of the government as well as the terrorists. This exacerbated our difficulties with accessibility to the people who needed our services most.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

In areas with strong social networks before a terrorist attack, the goal after an attack is to help sustain and support those networks to assist individuals and the community in their recovery. In areas where the social supports are weaker, a terrorist attack could further weaken those supports. The goal in this case is to identify members of the community who may be impacted by the further reduction of support to help them recover.

Before 9/11, taxi drivers might not have been an obvious group of people who could be affected by terrorism. But after the attacks and the downward spiral of the tourism industry, many taxi drivers found themselves out of work—and out of money. The stress of being unemployed only added to the anxieties of experiencing a terrorist event.

As families in Northern Virginia curbed travel and shopping in favor of the comfort and care of their homes, their decreased spending also led to lost jobs and high stress for:

- Displaced airport workers
- Small business owners
- Service industry workers
- Tourism industry workers

9/11 truly devastated everyone in the community in some way or another, and the different ways that it affected people really did surprise me. For example, how personally the airline industry took it, and how hard it was for them to think "Why didn't I catch the person?" "Why didn't I do this?"

June Eddinger
Project Director, Loudoun County
Community Resilience Project

Some data indicate that women may be more susceptible to the effects of terrorist events. Research following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City found that, compared with men, 6 months after the bombing, women had twice the rate of PTSD and more than twice the rates of depression and generalized anxiety disorder. Women are more likely to be single parents and caregivers for older adults or disabled family members. They also tend to be emotional caregivers for their immediate families.

Summary

To provide effective mental health services to different groups, disaster mental health workers are encouraged to assess their level of cultural awareness and seek to increase it by gaining an understanding of how these differences influence reactions to tragic events. Community gatekeepers and leaders are an invaluable resource during this process, as they provide information about vulnerabilities, access, communication, and other issues.

Understanding and appreciating different populations is not only about what is in a community profile or what gatekeepers have to say—it requires a continual assessment of the salient population groups that require assistance as a result of terrorist events, and looking at how they and their situations change. Be patient, be flexible—and be watchful. There will always be new groups to help and new ways to help them.

Additional Resources

American Fact Finder, http://factfinder.census.gov/servlet/BasicFactsServlet.

Athey, J. (2003). Developing cultural competence in disaster mental health programs: Guiding principles and recommendations. (DHHS Publication No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners, and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

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DiversityRx, http://www.diversityRx.org.

Fed Stats, http://www.fedstats.gov.

Jackson, G., Cook, C. (1999). Disaster mental health: Crisis counseling programs for the rural community. (DHHS Publication No. SMA 99-3378). Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

National Association for Rural Mental Health, http://www.narmh.org.

National Center for Cultural Competence
Georgetown University Center for Child and Human Development
3307 M Street, N.W., Suite 401
Washington, DC 20007-3935
Toll free: 800-788-2066
Tel: 202-687-5387
Fax: 202-687-8899
http://www.gucdc.georgetown.edu/nccc/

Office of Minority Health Resource Center
U.S. Department of Health and Human Services
P.O. Box 37337
Washington, DC 20013-7337
Toll free: 800-444-6472
Fax: 301-251-2160
http://www.omhrc.gov

U.S. Census Bureau, http://www.census.gov/population/www/index.html.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs, http://www.ncptsd.org/publications/disaster/index.html.

MODULE 5: EMERGENCY RISK COMMUNICATION

The "unknowns" of terrorism can be overwhelming. Limited facts about who, what, how, and why may create a swirl of rumors and misinformation that can increase confusion and anxiety. The public and the media will be looking desperately for answers—and one of the people they may turn to is a disaster mental health worker. It is vital that information and responses from disaster mental health workers are both appropriate and helpful.

In a non-emergency situation, a disaster mental health worker would have time to prepare, consult experts about what to say, and carefully choose one's words. But, communicating during a crisis is different. It is akin to what gets said in an emergency room versus what gets said in a doctor's office. The need is immediate, the impact is huge, and the pressure is high.

When terrorism happens, people want information—and they want it now. Some questions the public might ask include:

- What happened?
- How bad is it?
- Am I in danger?
- Is my family in danger?
- Who's going to help?
- What do I do now?

It is likely that disaster mental health workers will not always have all the answers. But there are important steps to follow to ensure that communication (to media, community groups, and individuals) is appropriate and helpful.

After completing this module, the disaster mental health worker will be able to:

- Recognize the importance of referring the media to designated spokespersons
- Recognize the disaster mental health worker's role in providing spokespersons with accurate and timely information
- Understand the key principles of emergency risk communication
- Build trust and credibility by communicating with the public
- Promote events and services effectively through a variety of channels
- Coordinate messages with appropriate agencies and organizations

The Role of the Spokesperson

During a crisis, spokespersons are a lifeline for getting the right message out the right way. City and county public information officers keep the public up to date on response efforts and public health recommendations. To do this, they assess information needs, provide information to the media, respond to media inquires, address other requests for information, oversee media monitoring, and make sure emergency communication principles are followed.

It is recommended that all information be passed to and filtered through a spokesperson. If a disaster mental health worker is approached or contacted by the media, it is critical that he or she directs the media to the appropriate spokesperson.

Your spokesperson is a vital link to getting the mental health message out to the public and making sure that this information is part of the overall communication after a terrorist attack. Get to know your spokesperson. Make sure that he or she knows you and what your organization does. Provide your spokesperson with fact sheets, speaking points, and sample press releases. Help him or her understand how mental health fits into the response to and recovery from a terrorist attack, and why it is important to communicate this information to the media and the public.

Amie Ware
Public Information Officer
Community Resilience Project

Supporting the Spokesperson

Mental health workers play a key role in providing spokespersons with appropriate mental health information and materials, as well as contact numbers that the public can use to obtain more information. Disaster mental health workers can assist spokespersons in providing the media and the public with up to date information on mental health information and services by taking the steps below.

- Identify the spokesperson for the organization, community, or county prior to an event.
- Establish a relationship with this spokesperson so he or she will know who to contact for mental health information before, during, and after an event.
- Provide the spokesperson with mental health information and services that are available so he or she will better understand how it fits into the overall response and recovery after an event, and can incorporate this information into the messages provided to the media.
- Communicate regularly with the spokesperson during and after an event to provide appropriate and necessary updated mental health information to help people start or continue their recovery process and to get help in coping with their reactions.

I think we were very successful working with the local media. The media were very open with having us on different talk shows. One time, the radio announcer said, 'June, why don't you call me once a month and just tell me what's going on?' So I was like his friend that would call and say, "Oh this is June, and we're doing this and this with the project."

June Eddinger
Project Director, Loudoun County
Community Resilience Project

- Make sure that the spokesperson has telephone numbers and/or Web addresses to provide to the media and the public for more information or services.

Emergency Risk Communication

Although disaster mental health workers usually do not play the role of media spokesperson, they will communicate with the individuals and community groups that go directly to them for information and services. It is critical that interactions with the public reflect Emergency Risk Communication (ERC) principles, including coordinating with other sources about what will and will not be said, and speaking simply and honestly. This will help channel the public's distress and direct people to take appropriate actions that protect their health and well-being. It also ensures that anything said by disaster mental health workers will be consistent with what others in public positions are saying. The table below outlines some ERC basics.

Table 5–1. ERC Basics[34]

What is ERC?	The art of providing information during a crisis: • That responds as quickly, accurately, and fully as possible • That educates individuals on the best possible choices they can make for their well-being • That communicates risks without creating panic • That acknowledges when facts are limited or unavailable • That enables resilience and recovery
Rules	• Realize that your goal is not to dictate what the public should do. Instead, give people information to keep them involved, interested, thoughtful, solution-oriented, and collaborative. • Listen to the audience. Find out what they know, what they are thinking, and how they are feeling. Provide information that addresses their concerns and uncertainties. • Earn trust and credibility—do not expect it. If you do not know or are unsure about something, say so. If you make a mistake, correct it. Be honest and open. • Coordinate with other sources. Take the time to build relationships and collaborate with other credible organizations. • Work with the media. Respect their formats and deadlines. Be open and accessible to them. Share background information and positive messages with them. • Leave "office-speak" at the office. Information that is shared with empathy and uses real-life stories captures an audience more than any jargon can. • Plan, deliver, and assess. Develop and communicate messages that meet the needs of the audience. Evaluate their impact and revise as appropriate.
What counts most	• Simplicity • Credibility • Verifiability • Consistency • Speed

[34] Centers for Disease Control and Prevention. (2003). Emergency Risk Communication (ERC) CDCynergy. Office of Communications, U.S. Department of Health and Human Services.

Perception of Risk[35]

Another important consideration in emergency communication is the perception of risk. A wide body of research exists on issues surrounding risk communication, but the following considerations emphasize that some risks are more accepted than others.

- **Voluntary versus involuntary:** Voluntary risks are more readily accepted than imposed risks.
- **Personally controlled versus controlled by others:** Risks controlled by the individual or community are more readily accepted than risks outside the individual's or community's control.
- **Familiar versus exotic:** Familiar risks are more readily accepted than unfamiliar risks. Risks perceived as relatively unknown are believed to be greater than risks that are well understood.
- **Natural origin versus manmade:** Risks generated by nature are better tolerated than risks generated by man or institutions. Risks caused by human action are less well tolerated than risks generated by nature.
- **Reversible versus permanent:** Reversible risk is better tolerated than risk perceived to be irreversible.
- **Statistical versus anecdotal:** Statistical risks for populations are better tolerated than risks represented by individuals. An anecdote presented to a person or community, i.e., "one in a million," can be more damaging than a statistical risk of one in 10,000 presented as a number.
- **Endemic versus epidemic (catastrophic):** Illnesses, injuries, and deaths spread over time at a predictable rate are better tolerated than illnesses, injuries, and deaths grouped by time and location (e.g., U.S. car crash deaths versus airplane crashes).
- **Fairly distributed versus unfairly distributed:** Risks that do not single out a group, population, or individual are better tolerated than risks that are perceived to be targeted.
- **Generated by trusted institution versus mistrusted institution:** Risks generated by a trusted institution are better tolerated than risks that are generated by a mistrusted institution. Risks generated by a mistrusted institution will be perceived as greater than risks generated by a trusted institution.
- **Adults versus children:** Risks that affect adults are better tolerated than risks that affect children.
- **Understood benefit versus questionable benefit:** Risks with well-understood potential benefit and the reduction of well-understood harm are better tolerated than risks with little or no perceived benefit or reduction of harm.

[35] Ibid.

Communication That Promotes Recovery

When communicating with the public, it is important to have an idea of where peoples' heads and hearts are, as well as the effect that certain messages could have on them. Following disasters, for example, some people may fall into a state of despair, where they believe that any attempt at recovery is doomed to failure. If—on top of all they are feeling—they receive mixed messages about how to recover, their sense of hopelessness could worsen and they could start to make unhealthy decisions.

After a terrorist attack, it is critical for officials to acknowledge that people may be feeling scared, sad, or angry, or that they may be having trouble sleeping, don't want to leave home, or are having stomach problems. In our communication efforts, we provided information to help people recognize potential reactions and understand that most of these reactions are normal and to be expected, and we offered suggestions about how to cope with them.

Amie Ware
Public Information Officer
Community Resilience Project

Interaction with the public can have a major bearing on reactions and recovery. While poor communication practices risk aggravating negative feelings and increasing confusion, effective communication leads to appropriate behaviors that promote health and well-being. Module 3 provides more details on the interventions and services that can be offered to the public.

What effective communication practices promote recovery?[36]

- Verifying and clarifying facts
- Displaying honesty and openness about what is not known or cannot be shared
- Expressing that a process is in place to get answers
- Displaying competence and expertise, without overstepping boundaries
- Expressing empathy
- Not over-reassuring
- Acknowledging uncertainty, fear, and other normal reactions
- Voicing commitment and dedication
- Considering the "what if" questions (i.e., worst case scenarios)
- Making referrals to appropriate spokespersons

[36] Ibid.

What poor communication practices negatively impact recovery?[37]

- Giving mixed messages from different experts
- Making unrealistic recommendations to the public
- Leaving rumors and cynics uncorrected and unchallenged
- Releasing information so late it is irrelevant
- Giving messages that are overly reassuring
- Showing public signs of power struggles and confusion within a responding organization or with other groups
- Using spokespersons who are uncompassionate, engage in inappropriate behavior, or exhibit improper humor

Being Trustworthy and Credible

Despite best efforts to communicate effectively with survivors, messages may not be accepted immediately. The public will look not only at what they are being told, but also at who is doing the telling and how. Disaster mental health workers must present themselves as trustworthy and credible sources.

To build trustworthiness, follow the guidelines below.

- Show caring. Display empathy by validating fears and suffering.
- Be honest about information that either is not known or cannot be shared.
- Avoid professional jargon. Give information clearly and concisely.
- Stay committed. Disaster mental health workers are in the community to help respond to the disaster. Work to meet that goal—even when the community has stabilized after the initial impact and the media has left.

To build credibility, the disaster mental health worker will want to take the steps below.

- Have an early presence. Establish a relationship with the audiences in the community before a crisis situation.
- Identify a third party, preferably a member of the audience in the community, who can vouch for you.
- Be speedy with a response—a slow one could indicate that a person or organization is not prepared. Deliver a message while it is still relevant.

[37] Ibid.

- Use indicators of expertise such as titles, educational background, and professional experience.
- Collaborate with other credible sources to make sure consistent and accurate information is delivered.
- Get the facts right, keep them up to date, and deliver them over and over again. Consistency is key.

Communicating During Different Phases of Terrorism

Effective ERC also follows the phases of terrorism. The information needs of the public and the media during the initial impact of an event will be different than when people have had time to process what happened and crisis counseling programs are in place. The table below describes the naturally progressing ERC cycle and shows how one can communicate effectively during every phase of an event.

Table 5–2. ERC Lifecycle[38]

Precrisis— **To plan and prepare**	• Anticipate questions and answers. • Draft fact sheets about your organization, common reactions to terrorism, and effective coping strategies, and other materials for the media, such as press releases, with blanks to fill in later. • Identify spokespersons and communication response resources. • Refine and train on communication plans. • Build relationships with experts and other response organizations.
Initial Phase— **When terrorism happens**	• Realize that there is intense media interest and widespread confusion. • Show empathy and compassion. • Put your spokesperson out front to show that your organization is facing issues head-on in a reasonable, caring, and timely manner. • Establish your organization as a credible resource and a place to go for help. • Inform the public about what people can do for their safety and well-being. • Let the public know that you are committed to keeping people informed.
Maintenance— **While continuing to assess the event**	• Stay informed about rumors, conflicting facts, and misinformation that may be circulating. Address them and help the public more accurately understand the situation. • Share background information about the event as appropriate. • Promote your response efforts positively and enthusiastically to gain understanding and support for them. • Provide information about common reactions and effective coping strategies. • Explain recommendations that are made to the public about the safety and well-being of individuals and the community. • Provide explanations that will enable decision-making.

[38] Ibid.

Resolution— As the crisis is resolved	• Realize that there is decreased public/media interest and increased understanding about the event and where to go for help. • Reinforce public health messages. • Continue to promote your services. • Examine mishaps and learn from them. Continue to focus on what works.
Evaluation— When the event is over	• Evaluate your communication activities. Glean from lessons learned and adapt your approach accordingly. • Document what worked and what did not work, as well as specific ways to improve your communication plan.

Promoting Community Services and Events

The media can be important allies in promoting disaster mental health services and events to the community. Without them, it can be difficult to communicate messages. Acknowledging the media's role in providing and sharing information with the public, and working to keep a cooperative relationship with them, is important. This can be accomplished by referring the media to the appropriate spokespersons, and following journalistic guidelines, such as those discussed below, when providing information about disaster mental health services and events.

In particular, when the demand for information is high, it is helpful to have a media kit on hand that can be readily accessed and dispersed. Fact sheets and press releases included in the kit give the media quick facts about the mental health service organization's history and mission, as well as information about common reactions to terrorism, effective coping strategies, what services and information are available, and how people can get more information by calling or visiting a Web site. This will reduce the margin for error. It is information that has been prepared and written down, so there is no mistaking the message.

Some essentials for a kit are:

- Press releases that answer the who, what, when, where, why (5 Ws), and how of the disaster mental health services available, including details about services and information, and how to get more information, such as Web addresses and toll-free numbers

- Backgrounders/fact sheets that give additional information, including common reactions to disasters, coping strategies, signs and symptoms of stress reactions, etc.

- Live announcer scripts for radio and television

When putting these together in advance, disaster mental health workers may consider using a "Swiss cheese" format that leaves holes where there is information that can be filled in only during or after a disaster, or that changes frequently. The blanks can be filled in when the document is actually going to be used. It is also important that kit materials follow basic journalism principles: for example, providing a contact person and phone number, e-mail address, and other ways of reaching the person at the top of the page; using a headline to describe the purpose of the document; double spacing the contents so the media can easily edit it; and including the 5 Ws in the first paragraph. Above all, the language should be simple, avoiding the use of professional jargon and technical or overly academic language as much as possible. The table below provides further guidance.

Have press releases and fact sheets ready to go so that, in the event of another attack, you can quickly fill in the most recent information and distribute them to the media right away. One of the things I have learned working with the Community Resilience Project is that there is very little time after an event to pull these things together. If you don't have information ready, you could miss your opportunity to be the "expert" and communicate your message. If you're not ready, the media will find another source for information that may be inappropriate or inaccurate, and it may be harder to establish yourself and your organization as a trusted and reliable source of information. So, be ready to respond the same day.

Amie Ware
Public Information Officer
Community Resilience Project

Table 5–3. ERC Media Kit Guidelines

Media	Task
Press Releases	• Limit to one to two pages. • Include your organization's name, address, telephone number, Web site address (if applicable), and contact name. • Give the media contact information for someone they can reach 24 hours a day. • Put an "OK" next to names that have unusual spellings in the opening section of the press release as well as in the body. This lets the media know those names have not been misspelled. • For a name that has an unusual pronunciation, include the phonetic pronunciation next to it. • If there is a toll-free number for the media to call for information, interviews, etc., give it to the media and stress that it is for them, not for the public. • Put "for immediate release" directly under your contact information. • Include the date or the date and time if you issue more than one release per day.

Media	Task
	• Include a headline, written in active voice, that summarizes the contents of your press release. Use a headline only once. • Write in the inverted pyramid style, giving the most important information first. • If a new information telephone line or Web site address is being introduced, present it early in the press release. • Use language that is easy to understand. Explain scientific or technical terms if necessary. • Eliminate all adjectives and emotional words. A good press release gives straight news. • End simply. Press releases do not have strong ending paragraphs. • Double-check facts. • Make sure the information does not violate anyone's privacy. • Get approval from the appropriate communication officer in your organization before issuing the press release. • If a mistake is noticed after sending out the press release, make every effort to reach everyone who has it and give him or her the right information. If it is too late, do the same and apologize. For some examples of press releases and a press statement template, see Appendix B.
Fact Sheets/ Backgrounders	• Attach to press releases. • Can be more than one page. • Write fact sheets in a bulleted format. Use paragraphs for backgrounders. • Include information that is not expected to change. Press releases are the place for updates. • Backgrounders give historical information as well as more in-depth explanations of material in fact sheets. Both should go from broad to specific details. • Define scientific and technical terms. • Fact sheets and backgrounders make good material for media Web sites. Make sure they are error-free before releasing. • Do not include quotes from officials or experts. • Get approval from the appropriate communication officer in your organization before issuing.
Live Announcer Scripts	• Attach to press releases. • Use to provide toll-free numbers or other numbers for the public to call, Web site addresses, or to promote specific services. • Provide :10-, :15-, and :30-second scripts for radio "filler" time to be either read live or taped by radio personnel. • Get approval from the appropriate communication officer of your organization before issuing.

Other do's and do not's for keeping a cooperative relationship with the media include:

Do

- Refer them to your organization's spokesperson.
- Make yourself available to them if approved by your organization.
- Realize that they decide what goes in their broadcast or publication and what they tell their audience.
- Make suggestions for the most important points to cover in the story or suggestions for other people to interview.
- Make points clear, concise, and consistent.
- Acknowledge when you do not have enough information or are unclear about something.

Do not

- Ignore them.
- Give them any information without the approval of the appropriate communication officer.
- Spoon-feed them stories or headlines.
- Dictate what you think they should put in their broadcast or publication.
- Expect that what you think is news will always be considered news by the media.

Other Methods for Getting the Word Out

The media is not the only option for promoting an event or organization. Other ways to reach mass audiences include the following "tried and true" channels:

- Telephone hotlines
- Fax and broadcast preprogrammed fax
- E-mail and listservs
- Mass mailings and mailing lists
- Partners and other response teams
- In-person communication in supportive environments (e.g., churches, clinics)
- Web sites and links to your Web sites
- Paid advertising
- Public Service Announcements (PSAs)
- Brochures, flyers, and posters to display in stores, doctors' offices, and restaurants
- Community newsletters

We've created brochures in different languages. We've conducted outreach on Vietnamese radio and Hispanic radio, for example, because that was a better medium… We've had to be innovative… We were very fortunate to have these community-based organizations to work with. If we had not, it would have been a very slow, arduous start of the services that would have taken place much later.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

Nontraditional methods of communication are helpful as well. These include brainstorming with colleagues and seeing what ideas develop—the possibilities are endless. Message placement opportunities include:

- Pizza boxes
- Subway stations
- Veterinary offices
- Hair and nail salons
- Diner placemats and coasters at bars where first responders gather
- Stress balls
- Emery boards
- Updateable message boards, such as those in front of gas stations and fire departments

One of our outreach workers went to a pizza establishment in the area to promote the program and learned that the establishment occasionally puts flyers on top of their pizza boxes. They offered to do that for us, announcing and promoting our program. So we did it twice. The first time, about 10,000 people got this information into their homes. The second time we did it, about 9 months later, we not only promoted our program but also promoted stress management coping guidelines.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

Maximizing the Effectiveness of Web Sites

The Internet is increasingly becoming one of the most important communication channels for reaching the public. Provide Web site visitors with organizational contact information, the kinds of services that are available and how to access them, explanations about common reactions and effective coping strategies, and stress relief tips. Also consider tailoring information for various audiences, including adults, children, parents, teachers, first responders, mental health workers, and the media. Be sure that information on the Web site is kept up to date.

Including Web address information on all press materials, brochures, flyers, newsletters, and other materials created for the public is essential. To help ensure that people know about the Web site, consider issuing a press release that describes who the site is for and the information that is available on the site.

Languages and Literacy Issues

When disaster mental health workers are choosing the types of communication to use, it is critical for them to be aware of issues that could impact how the message gets communicated and which channels will be the most effective and appropriate to reach specific audiences. Audiences that speak a different language or have low literacy skills pose potential barriers that must be addressed so they can be reached effectively. Module 4 provides an overview of how to identify issues among different populations.

Summary

During a crisis, the media and the public want information frequently and urgently. Disaster mental health workers need to know who the spokespersons are for their agency/organization; must provide mental health information to them before, during, and after an event; and should refer all media inquires to them. Acknowledging the media's role in providing and sharing information with the public, and working to keep a cooperative relationship with the media is also very important. When communicating with individuals and the community, disaster mental health workers should be aware of the ERC principles, which include coordinating with others to determine what will and will not be said, and speaking simply and honestly. When promoting services and events, disaster mental health workers cannot only tap their relationships with local media, but must also look for non-media communication opportunities, such as telephone hotlines, Web sites, or posters where community members congregate.

Additional Resources

Centers for Disease Control and Prevention. (2003). Emergency risk communication (ERC) CDCynergy. Office of Communications, U.S. Department of Health and Human Services. (To order a copy, contact Judith E. Courtney at 404-639-7825.)

The Peter Sandman risk communication Web site, http://www.psandman.com/.

MODULE 6: SAFETY AND WELLNESS OF DISASTER MENTAL HEALTH WORKERS

Although providing mental health support during a crisis can be very rewarding, it also can be stressful, even for the most seasoned mental health professional. The effect of a terrorist event, personally and professionally, may be more severe for some disaster mental health workers than others. Although disaster mental health workers typically work with crime victims and other people who have experienced trauma, they may not be accustomed to working in an environment impacted by terrorism.

The needs of the survivors of terrorism may be overwhelming. The large scale of the terrorist impact may mean there is a limitless amount of work to be done, and disaster mental health workers may feel the need to push themselves beyond their usual limits. Due to the extensive needs of victims and their family members, it can be difficult to leave the scene and go home, or to take a break when assistance is still needed. But it is important for disaster mental health workers to monitor themselves and to take care of personal needs so they will have more energy to help others.

After completing this module, disaster mental health workers will be able to:

- Understand the need for self-care and personal safety
- Monitor their own physical and mental health during a terrorist event
- Work with team members, supervisors, and/or other counselors to promote a supportive work environment
- Identify stress management techniques, such as debriefing, that may be helpful for themselves and other disaster mental health workers in the aftermath of an act of terrorism.

Self-Care Before the Event

Disaster mental health workers need to:

- Assess their willingness to engage in a terrorist event response
- Assess their strengths and weaknesses in crisis situations
- Make personal preparations in advance

Below are some specific factors that disaster mental health workers may want to consider as they start to plan for a possible terrorist event.

- *Management structure and support.* Is the organization that the disaster mental health worker works for prepared to respond to a terrorist event? Will there be special training in disaster counseling?

- *Social support.* Does the disaster mental health worker have a strong support network of peers, friends, and family to count on?

- *Competing demands*. Are there family responsibilities to deal with? Are there ways to plan ahead of time to meet those responsibilities?

- *Environment.* Is working in settings that may potentially be unpredictable, hectic, and noisy tolerable? How does the disaster mental health worker feel about meeting clients in places other than his or her office?

- *Personality.* Is the person flexible and able to adjust to conditions that may change rapidly? Can the disaster mental health worker concentrate when there are a number of stimuli competing for his or her attention? Is he or she a positive, optimistic person?

- *Physical health.* Are there health considerations that limit the person's ability to work in certain conditions or environments? Does the disaster mental health worker have a lot of stamina? Does he or she take care of him or herself when under stress, or does the person tend to get sick?

- *Prior traumas.* Has he or she experienced prior traumas of any sort (e.g., disaster, accidents, abuse)? Will certain kinds of situations have personal significance due to prior experiences? (Note: Prior traumas may make it more difficult for some people, but easier for others. The person will need to decide for him or herself, based on whether the emotional issues surrounding the earlier trauma have been resolved.)

- *Prior mental health issues.* Are there past mental health issues that may affect adjustment or functioning in a disaster setting?

The decision about whether to do disaster mental health work during or after a terrorist event is a personal one that depends on knowing oneself, including one's reactions and limitations. If mental health workers do decide that this kind of work is for them, they can take the steps listed below in advance to help adjust to working in a disaster setting.

- *Make arrangements for personal responsibilities.* If they have children that need to be taken care of, financial responsibilities, or other personal demands that may compete for their attention during a disaster, they might want to try to make arrangements ahead of time.

- *Create a self-care plan.* They may want to have a detailed, written plan for how they will take care of stress and their health while doing disaster work (there is additional information on this later in this section).

- *Participate in drills and other disaster training.* Although training can never completely simulate a disaster, training can help prepare them for some of the issues that may arise in a disaster setting.

- *Work with organizations to make workplace preparations.* They can work with their managers and colleagues to develop emergency response plans and discuss the details of how work will change during a disaster (e.g., whether regular work will be reassigned, whether attendance at additional team meetings be required).

Self-Care During the Event

When considering self-care during or after a terrorist event, it is important to examine two separate areas: emotional care and personal safety. Emotional care involves protecting one's own mental health and functioning, and personal safety refers to being aware of physical risks that one may be exposed to when involved with crisis response.

Emotional Care

Emotional care is particularly important in a terrorist situation because the disaster mental health worker may also be considered a survivor of the event. Even if the disaster mental health worker did not experience the same kind or degree of trauma as those who are seeking counseling, he or she is still personally coping with the event. Few people who respond to a mass casualty event remain untouched by it. The disaster mental health worker may experience sadness, grief, or anger—but deny his or her needs for rest and recovery to help others.

As a clinician, the thing that was most surprising for me was the issue of what is called "vicarious trauma." Keep in mind that this event was an event that happened to us all, including the service providers, and, because of that, we as clinicians had to be very mindful of keeping our own "stuff" out of other people's "stuff." As a manager of staff providing services, vicarious trauma became a critical issue as well…I had to manage our staff's process while they were in a process of providing services. So, I think vicarious trauma is a very critical clinical issue…where almost everyone is a victim by virtue of having seen the event on television, either in real time or delayed time…As clinicians in service to trauma victims, perhaps one of the most important points we have to remember is that trauma work is not traditional work.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

An important tool in protecting one's emotional health during a crisis is one that disaster mental health workers probably use already in their regular roles as counselors—setting personal boundaries. By determining personal boundaries before the crisis occurs, the workers will be better able to take care of themselves. These may be different personal boundaries than those typically set. For example, in regular practice, disaster mental health workers may have people leave messages with an answering service after a certain time of the day. However, in a crisis, they may choose to extend hours or make sure that people talk directly with another mental health provider.

The personal boundaries that disaster mental health workers set will require a realistic assessment of their limits and what is needed to be effective in treating others. Keep in mind that it may be harder to maintain personal boundaries in a crisis because a disaster mental health worker also may have endured the same event, which can make it harder to remain emotionally detached. A few examples of personal boundaries that could be set include:

- Limiting exposure to media coverage
- Setting work hours (e.g., limiting shifts to 12 hours or less)
- Referring someone to another provider if the issues that come up are beyond one's expertise

Continual Self-Monitoring

All disasters are inherently stressful. Disaster work can be intensely meaningful and rewarding, as well as traumatic. Even the most experienced disaster mental health worker needs to be attentive to his or her own stress responses. Continual self-monitoring is an important component in managing stress. Although this may seem obvious, when someone is involved in a response to a terrorist event, self-monitoring may seem like a luxury. Functioning well will depend on many factors such as stamina, expectations, prior traumatic experiences, and even eating habits. The way one functions in his or her regular role as a mental health professional may be very different from functioning in a crisis. Therefore, continual self-monitoring is critical to make sure that stress is at a manageable level. Many counselors from the Community Resilience Project (CRP) found it helpful to partner with a friend or colleague to help monitor each other's stress levels to determine when relief was needed.

The *Self-Monitoring Checklist* below can be used to measure stress levels following a terrorist event. Experiencing a few of the listed symptoms generally does not constitute a problem, but experiencing several symptoms from each category may indicate a need for stress reduction. By taking care of oneself, the disaster mental health worker will be better able to care for the victims. Some stress reduction suggestions follow the checklist.

Self-Monitoring Checklist[39]

Check off anything that pertains to feelings, thoughts, or behaviors in the last 24–48 hours.

Behavioral

- ❑ I am more or less active than normal.
- ❑ I am not as effective or efficient as usual.
- ❑ People do not seem to understand what I am trying to say.
- ❑ I feel irritable or angry all the time.
- ❑ I cannot seem to rest, relax, or let down.

[39] Carter, N.C. (Draft, 2001). Stress management handbook for disaster response and crisis response personnel. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- ❑ I am eating a lot more/less than usual.
- ❑ I have trouble sleeping/am sleeping too much.
- ❑ I cry a lot or feel like crying all the time.
- ❑ I am drinking or smoking more than I usually do.

Physical

- ❑ My heart seems to beat fast all the time.
- ❑ I have an upset stomach, nausea, or diarrhea more often than normal.
- ❑ I have been gaining/losing a lot of weight.
- ❑ I perspire more than normal or often have chills.
- ❑ I have been having headaches.
- ❑ I have sore or aching muscles.
- ❑ My eyes are more sensitive to light.
- ❑ I have lower back pain.
- ❑ I feel there is a "lump in my throat" all the time.
- ❑ I jump at loud noises or when people come up behind me.
- ❑ I sleep okay, but I am still tired.
- ❑ I cannot get rid of this cold/I feel I am coming down with the flu.
- ❑ My allergies, asthma, arthritis, or other chronic health condition(s) have been bothering me more than usual.

Psychological/Emotional

- ❑ I have been on a natural high/an adrenaline rush for days.
- ❑ I feel anxious or fearful often.
- ❑ I can't keep my mind on my work.

- ❑ I feel sad, moody, or depressed.
- ❑ I have been having disturbing dreams.
- ❑ I feel guilty about what the survivors are going through.
- ❑ I feel overwhelmed, helpless, or hopeless.
- ❑ I feel isolated, lost, or alone.
- ❑ No one seems to understand or appreciate me.

Cognitive

- ❑ I am having trouble remembering things.
- ❑ I get confused easily.
- ❑ I cannot figure things out as quickly as I usually do.
- ❑ I keep making mistakes or cannot make decisions well.
- ❑ I have trouble concentrating.
- ❑ I cannot quit thinking about the disaster or incident.

Social

- ❑ I do not want to be around people.
- ❑ I do not want to listen to people.
- ❑ Trying to work with the group seems like a waste.
- ❑ I just do not like to ask for help.
- ❑ People seem so slow or unresponsive.

Some Things One Can Do to Reduce Stress and Renew Energy

- Take a walk or stretch.
- Stop and breathe deeply for a few moments.

- Talk to a trusted friend about your situation.
- Eat nutritious foods (e.g., lean protein, whole grains, fruits and vegetables) and avoid sugar, caffeine, and alcohol.
- Take a hot bath.
- Read a humorous or interesting book on a topic completely unrelated to what you are dealing with.
- Sit in a dark room for a few minutes to help relieve headaches.
- Get to sleep early, if possible.
- Be patient with yourself.
- Ask people who have been through a similar experience how they handle their stress.
- Get a friend to partner with you for stress monitoring and reduction.
- If you feel lonely or isolated, ask someone to go to dinner or a movie.
- Meditate.
- Exercise.
- Spend some time with friends, family, and/or pets.
- Try to stick to your morning and/or evening routines as much as possible.
- See if shifts can be rotated with a colleague so that neither person is doing high-stress work day after day.

It also is very important to limit exposure to the event when off-duty. Although it may be tempting to watch news and updates about the event on television, it is best to limit exposure to the media. A study on psychological responses to the events of 9/11 indicates that the number of hours of television coverage an individual watched per day in the days following the attacks correlated with the development of Post-Traumatic Stress Disorder (PTSD) or symptoms of clinically significant psychological distress in that individual.[40]

Personal Safety

Personal safety, especially when making home visits and when in the area of the terrorist incident, can be an issue when a disaster mental health worker responds to a terrorist event.

[40] Schlenger, W.E., et al. 2002. Psychological Reactions to Terrorist Attacks: Findings from the National Study of Americans' Reactions to September 11. JAMA, 288(5), 581–588.

To reach people affected by the event, disaster mental health workers may need to go door-to-door in isolated, high-crime, and/or unfamiliar areas, sometimes in the evening. It is important to keep safety in mind at all times and to help other team members stay safe. It is also crucial that one also trusts his or her instincts. Some possible ways to protect oneself in potentially dangerous situations include:

- Conducting outreach in teams, if possible
- Making sure to carry a cell phone and a local map
- Determining the safety of an area before going there alone
- Dressing appropriately (i.e., counselors should not stand out from the crowd)
- Checking in with supervisors, other mental health workers, and/or friends and family at pre-agreed time intervals or maintaining a daily log with arrival/departure information
- Assessing the environment (e.g., being alert for unusual or dangerous activity/persons, honoring any request to leave)
- Determining with managers, team members, and/or other mental health workers before a mental health worker starts going out into the field what situations he or she absolutely should never get into (e.g., approach a house with a big dog in the yard), what possible dangers could be encountered, and which areas should not be entered under any circumstances

Depending on the nature of the event, the disaster mental health worker also may need to monitor his or her surroundings for potential environmental dangers and be ready to evacuate the area immediately if necessary. For example, after 9/11, responders had to be aware of the possibility that damaged buildings could collapse at any time.

Promoting a Supportive Work Environment

Ideally, a self-care plan functions in tandem with support in the work environment from supervisors, team members, and/or other counselors. The type and source of support for disaster mental health workers in structured organizations may be different from those in private practice or those seeking outside support.

Within Organizations

- Managers or supervisors may provide support within an organization. For example, managers may foster a supportive culture and programs that support staff (information for managers is covered in detail in Module 7).
- Team members and other mental health workers also may provide professional and emotional support. Having the opportunity to talk with other team members is important for processing what people are thinking and feeling, and for getting additional perspectives on problems.

- Having an open dialogue and clear lines of communication between managers and counselors and between team members at all levels is helpful.

In Private Practice or for Those Seeking Outside Support

- Other counselors doing disaster mental health work can provide support for each other either individually or through small formal or informal groups. Keeping in touch with others doing disaster mental health work is critical for one's emotional health and for keeping updated on how the community as a whole is functioning.

In addition to communication, there are other ways that the team members in the work environment can support each other in a crisis situation. Some examples are listed below.

- **Encourage team members to take breaks.** Heeding the team's advice on breaks is good not only for those taking the break but also for the team, as people will return to the team with renewed energy and will be better equipped to serve their clients.

- **Meet on a regular basis.** Meetings with team members are vital to ensuring that everyone has the same information and is functioning effectively. Depending on the situation, the team may want to meet every few hours, every day, or every couple of days. Meetings help team members feel less isolated and provide a forum to help each other solve problems that may arise. Meetings are also a good way to take continual stock of how well everyone is coping.

> *The key to good services is a healthy and happy service provider. We worked hard to ensure that the outreach team was as stress-free as possible. To help achieve this goal, we had weekly 2½-hour meetings to address program issues, deployment, personal stress management, and training, as well as weekly 30-minute meetings with each individual on our team. We also made sure that they understood the purpose of the outreach activities and that they had the tools to facilitate them.*
>
> Deborah Warren, L.C.S.W., D.C.S.W.
> Project Director, Alexandria
> Community Resilience Project

- **Participate in emergency procedures/drills and planning.** Participating in drills is an opportunity to test personal and team reactions to a crisis and find ways to improve before a terrorist attack happens. Drills can also be helpful in team building and making the response to an actual crisis go more smoothly.

- **Acknowledge fellow staff members.** Although it is rewarding to receive acknowledgement for a job well done from a supervisor, it is also gratifying to receive positive recognition from a colleague. Expressing positive reinforcement publicly is a great way to help build a positive, supportive atmosphere among team members and help boost morale.

- **Normalize getting help.** Management and other colleagues can help foster an atmosphere where it is considered acceptable to debrief with colleagues, access Employee Assistance Programs, or get other professional help. Conducting formal debriefing as described in the next section may also help.

Other Stress Management Assistance

It can be very difficult for disaster mental health workers to hear about the traumas of survivors for days on end, and some may begin to suffer from vicarious traumatization. Several ways of managing stress and preventing burnout are discussed in this section.

Debriefing

One way to try to manage stress levels is by debriefing, which is a process that can help people understand and manage intense emotions, develop more effective coping strategies, and receive support from their peers. Either in pairs or in groups, colleagues may do informal debriefings on a case-by-case or daily basis. Informal debriefing may simply involve talking about the current thoughts and feelings someone is experiencing. It may even be a short, spontaneous conversation for a few minutes in a break room. Debriefing can focus on a specific incident or the buildup from multiple stressful incidents over a period of days or weeks. Debriefing can also be a more formal, structured, confidential process for the staff at a particular site or in a particular work group.

Many disaster mental health workers may be familiar with the concept and methods of debriefing, but they know the technique from the perspective of the facilitator, not the participant. A group of these workers in Northern Virginia found that debriefing was a great tool for normalizing feelings, thoughts, and reactions that they experienced and for removing some of the stigma of getting help for themselves.

While we were going through the different phases of coping with 9/11, new events like the sniper attacks and the continued terror alerts launched people back into a previous phase of recovery. The cumulative stress that the individuals in our community were experiencing from all of these events, as well as the stress that these events put on the staff, made it that much more critical for us to come together, work to promote team-building, talk about what was working and what wasn't, and share our experiences. This helped us help each other.

Deborah Warren, L.C.S.W., D.C.S.W.
Project Director, Alexandria
Community Resilience Project

Debriefing is likely to be done up to a few days after the event or may happen as the event progresses. Several follow-up debriefings may be helpful in the weeks, or even months, following the end of the response to the event, as people's reactions to an event may take a while to surface or new issues many arise as time goes on. Even debriefers may need a special debriefing at some point, as they can also suffer from vicarious traumatization. More details about how to conduct debriefings are covered in Module 3.

For people who have difficulties with self-assessment and taking time for themselves, debriefing techniques may demonstrate the need for additional self-care and even professional help. In addition, if those conducting the debriefing are from another outside organization, they may be able to provide new alternatives or resources that people had not considered previously. These techniques may not provide all of the support that disaster mental health workers will need, but can be very helpful.

Other Types of Interventions

For disaster mental health workers who are working within an organization, supervisors can be very helpful in ensuring that their workers are functioning well during a crisis. Supervisors can work individually with employees in several ways. One way is to discuss individual cases with the employees to determine if the disaster mental health worker's expectations for the client are realistic and to see if the client is resolving his or her problems. Supervisors can also help their employees in further developing their skills (e.g., how to respond to strong emotions expressed by a client) and in determining when the needs of the client are greater than what the counselor can provide. In addition, supervisors can help monitor caseloads and help disaster mental health workers learn how to end counseling relationships as appropriate.

Group supervision can also be helpful for disaster mental health workers. The group doesn't necessarily need to be working for one organization. It could consist of people working with specific types of clients, in a specific geographic area, or the group may have another common bond. Group supervision differs from a regular staff meeting or other gathering in that the focus is on the clinical and counseling aspects of the job. Issues that can be addressed in a group setting include difficult cases, heavy workloads, and skill building.

In-service trainings also may be very helpful for those who are doing disaster mental health work over an extended period of time. These kinds of trainings will pull the counselor out of the crisis environment for a few hours or a day so that they can build on their existing skills, take a break from the crisis, and participate in team-building activities. For example, a ropes course is a great way to encourage problem-solving in a group setting and gain an appreciation for the abilities and skills of other team members.

Summary

To be effective in their jobs, disaster mental health workers must make self-care a priority, ensure that their physical and emotional needs are met, and determine that they are working in a safe work environment. Supervisors and organizations can be very helpful in providing support to disaster mental health workers in many ways, including providing assistance with cases, fostering an environment where teamwork thrives, and providing debriefings and other mental health services. There are also many ways that disaster mental health workers can directly reduce their own stress and that of their fellow workers. Although getting support is more challenging for those who work independently (e.g., in private practice), there are many sources for support outside the immediate work environment, including family, friends, and other counselors.

Additional Resources

Carter, N.C. (Draft, October 2001). Stress management for disaster response and crisis response personnel. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

MODULE 7: TOOLS FOR MANAGERS

Managers of programs providing mental health services are called upon to make difficult decisions daily. However, when a terrorist event occurs, the types of decisions they must make change in relation to the specifics of the event. Who will they send to respond, and how will services be delivered? Where will staff go and to whom will they report once they get there? Often, these decisions must be made quickly and with little information. And, as new information becomes available, these decisions are reevaluated and adjusted, as necessary. The key to being a successful manager during an act of terrorism is maintaining flexibility and creating a supportive work environment.

Most of the information in this module provides guidance on how managers can prepare themselves and their staff before a terrorist event. The last section focuses on the managerial role during the immediate and early aftermath of a terrorist event.

After completing this module, a manager will be better able to:

- Identify necessary steps for staff planning and preparation
- Assess the strengths and limitations of staff and new hires
- Prepare staff to respond to a terrorist event
- Manage logistics and resources
- Provide a supportive work environment for staff
- Identify their role in managing the provision of mental health services following an act of terrorism

Establishing Consistent Management Practices and Protocols

Managers may already employ many of the following practices in their immediate workplace environment. If they belong to a larger organization, they might consider the management practices listed below from a broader perspective.

- **Establish a clear chain of command.** Do staff members at every level know to whom they report and who reports to them? Even more importantly, would staff know whom to contact if the manager was not accessible or available? When terrorism hits, a clear chain of command means knowing who to go to for answers and assignments. Call trees, organizational charts, and cluster meetings are all visible ways to promote and reinforce the chain of command.
- **Provide regular supervision and feedback.** Managers understand the importance of regular supervision and feedback. However, during times of crisis, the value of periodic "check ins" with staff is increased as staff experience prolonged periods of stressful work

conditions. Prior to a crisis, develop a system for evaluating the abilities and contributions of staff, recognizing their achievements, and providing them with constructive criticism. In addition to regular debriefings and other meetings, work with staff to identify how they would like to receive feedback and with what frequency. Keep in mind that it may be necessary to adjust this plan to increase the level of supervision, depending on the nature and severity of the crisis.

- **Nurture relationships with gatekeepers.** Foster relationships with other mental health teams in the area, as well as with local, state, and national response agencies, from the perspective of a response to terrorism. Make sure these agencies are familiar with the staff's capabilities, the services available, and other resources that may be useful during a response effort. Not only will this help to position the organization as a reliable and willing partner, it may help to provide the manager with a place at the decision-making table during pre-event planning sessions, as well as with increased access to information during the immediate aftermath of a terrorist event. Gatekeepers of particular importance include city and county officials, and counterparts in other human services organizations.

Assessing Staff's Strengths and Limitations

While there is no formula for the perfect disaster mental health worker, there are traits that make some people better suited for disaster mental health work than others, and the importance of these attributes is amplified in a disaster setting. It is also important to recognize that even the very best mental health worker may not be equipped or may prefer not to be exposed to a site involving mass casualties. Therefore, it is advisable to assess staff's strengths and limitations prior to an event, if possible, and to identify in advance those who are both willing and able to provide services at a disaster site.

Crisis counseling services surged in response to each new terrorist related incident…The greatest strength of our staff was their ability to develop a style of operating that was flexible and responsive to daily events.

Diana Nordboe, M.Ed.
Regional Coordinator
Community Resilience Project

Because of the intense chaos that is the very essence of a disaster site, the "ideal" disaster mental health worker should, at the very least, possess calmness under pressure, community "connections," and the ability to work with some degree of independence. The following chart of attributes may be used to help guide decisions regarding how to staff an emergency management team, as well as to assist in making hiring decisions.

Table 7–1. Staff Attributes[41]

Attribute	Look for . . .	Watch out for . . .
Quick-thinking initiative	• Natural curiosity • Learning gleaned from experience • Creative solutions to complex problems • Flexibility • Organization in the midst of chaos	• Thrill seekers and "adrenaline junkies" • Extreme risk-takers and those who engage in dangerous behaviors • People who depend on routine and stability
Sociability with clear personal boundaries	• Finding the silver lining—making the best of difficult situations and seeking the best in others • Team player • Approachability • Friendliness • Genuineness • Tact • Discretion	• Over-involvement with survivors • Insincerity or artificiality
Clear professional boundaries	• Familiarity with incident command issues • Recognition and respect of operations at local, state, and national levels • Impartiality	• Overconcern with turf issues • Instigators of organizational struggles
Natural counseling skills	• Empathy—ability to make survivors feel they are understood • Supportive and active listening skills—asking the right questions, validating survivors' answers and feelings, and helping ease confusion and worry • Respect—positive and appropriate attention paid to survivors	• Inability to accurately summarize and reflect others' feelings • Rigidity and formality • Disrespectful tone and body language • Tardiness

In addition, mental health *para*professionals may be recruited from existing community programs such as crime victim advocacy and services programs, senior outreach services, religious-sponsored programs, cultural group-oriented service programs, or disaster response volunteer organizations. These workers often reflect the demographic characteristics, as well as the ethnic and cultural groups present in the disaster-affected community. Solid interpersonal communications skills, the ability to work cooperatively with others, the capacity to help others without judging, and the ability to maintain confidentiality are desired qualities for paraprofessional staff.

[41] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs. Available at: http://www.ncptsd.org/publications/disaster/index.html.

As managers take stock of their staff's particular strengths and limitations, it is recommended that they also assess which staff members have specialized skills that might be particularly useful during a crisis. Consider the questions below.

- Do some staff members have experience responding to acts of terrorism or mass trauma, and would staff with less experience benefit by partnering with them?
- Are there other staff members who would be particularly good mentors to younger or less experienced staff?
- Which staff members have specialized skills—such as language capabilities or strong community associations—that might increase access to the populations being served?
- What other types of specialized skills or attributes might influence emergency management plans?

Preparing Staff for a Crisis

To identify training needs, managers may consider simply asking their staff members if there are additional skills or topic areas in which they would like to receive training to better equip them to provide mental health services after an act of terrorism. This will also help assess their individual levels of confidence and readiness to respond. (Note that the training needs of paraprofessional staff may be different from those of mental health professional staff. Paraprofessionals should be referred to Module 8 for guidance.)

Disasters are highly stressful events for both the victim and the disaster worker. In my experience, terrorism has been the most difficult type of disaster to respond to and has a stronger emotional impact on workers than natural disasters. Training is needed before an event to prepare crisis counselors to deal with what they may hear, see, and experience after a terrorist incident. Many of us were better at helping others than taking care of ourselves. In-service trainings and weekly meetings should reinforce the importance of self-care.

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Regional Coordinator
Community Resilience Project

While managers may know which staff members were hired as essential personnel, it is important to ensure that all staff members are familiar with this designation, understand who possesses it, and know what it means. The qualifying characteristics of essential personnel include:

- Willingness to serve as essential personnel
- Availability on short-term notice for disaster assignments
- Demonstrated tolerance for long hours, substandard facilities, turbulent environments, and organizational struggles
- Understanding of the risks associated with responding to terrorist events
- Ability to make arrangements for current clients to receive care in their absence

Essential personnel, in particular, need to understand what will be expected of them and to be prepared to fulfill their responsibilities. It is important that managers remind all personnel, and especially essential personnel, that having a family preparedness plan, including provisions for childcare and communication with their families during a crisis, is critical to their ability to comply with their job descriptions.

Another area that might require additional staff training is in complying with the regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. One part of the law is intended to reduce the burden of health care administration by standardizing administrative processes and making them electronic. If staff have questions regarding HIPAA compliance or need further training on the subject, this information can be found in fact sheets and appropriate training resources on the Centers for Medicare and Medicaid Services' HIPAA Web site: http://www.cms.gov/hipaa/.

Managing Logistics and Resources

Unclear directions and inadequate resources add to the confusion and stress of responding to a terrorist event. Managers can help reduce or avoid this by establishing clear logistical plans and protocols that guide their staff members through the steps of what to do.

Call-up lists, for example, are useful in transmitting information to a large number of people through a network of supervisors. If these lists are rehearsed frequently, mental health workers will know who their guidance will come from during a crisis and where to report if they are deployed.

It is important that procedures be established in advance for how teams of mental health workers will consistently identify and introduce themselves to prevent confusion. Tactics for distinguishing themselves from other volunteers on-scene might include:

- Wearing matching T-shirts
- Carrying badges with photo identification and official insignia
- Identifying themselves with vocational phrases such as "outreach workers"
- Carrying letters of introduction on official letterhead

In addition to materials for gaining access to a site, staff need appropriate resources to manage crisis situations, such as cell phones or text messaging equipment. Backup communication systems are an important element to ensure that a technical breakdown in communication does not disrupt response efforts. Consider the suggestions below.

- Use disks rather than the hard drives on staff computers (if hard drives are used, they should be backed up regularly to an off-site location such as the city government, another CSB office, or other partner organization).
- Use palm pilots and other personal digital assistants (PDAs).
- Have cell phones with text messaging capability for workers in the field.

- Store emergency phone lists and other documents in multiple locations.
- Develop innovative planning solutions, such as employing the communication channels in school buses. (Two-way radios in school buses may work even if phone systems malfunction during a disaster. In the event of a communications breakdown and cellular connections being overwhelmed, one Northern Virginia county had plans to deploy school buses to specific locations. Staff knew to go to these locations, where they could wait for and receive information.)

Creating a Supportive Work Environment

Successful mental health response depends on workers who are committed to taking care of survivors—and themselves. Managers can take the lead by creating an atmosphere of team empowerment and creativity, by being accessible and approachable, and by establishing open lines of communication with staff members.

Staff attrition has been low despite the stressful nature of the work and the length of the project. The crisis counseling and outreach staff are deeply committed to helping victims and the community recover from 9-11. Team spirit is a major strength of the project that sustained staff during the most challenging times. This has been both a rewarding and heart-breaking experience that has given each of us the opportunity to grow both professionally and personally. I consider it a privilege to have worked with such dedicated and caring people.

Diana Nordboe, M.Ed.
Regional Coordinator
Community Resilience Project

Ways to foster a supportive work environment include:

- Creating structure through regular meetings, established due dates/expectations for paperwork, and a staff review schedule
- Organizing team- and skills-building activities
- Displaying openness to new ideas
- Establishing policies and procedures for setting limits for staff
- Encouraging staff to take care of personal family issues

On Fridays, program meetings were spent touching base with each other, finding out where people were, sharing stories, and giving the opportunity to ventilate and process. I also think it was productive for staff to share their plans for the weekends. Part of my job as a manager, although I didn't do a very good job taking care of myself and I acknowledge that, was to make sure that my staff was taking good care of themselves. I think the more the project managers got to know each other and became our own working team, we were then able to serve that function for each other—being able to process and check in with each other and see how we're doing, or have someone tell you that 'you really need to take Friday afternoon off, you sound tired.' It has to be an effort of concern and caring and teamwork to ensure both the workers and the managers each are engaging in good self-care.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

In addition, managers of programs that provide mental health services to clients on a regular basis, whether on an outpatient or inpatient level, will need to decide which staff to send into the field and which staff to retain to provide continuity of care to existing patients. Managers need to consider the following guidelines when managing onsite staff who will also likely be required to work extended periods of time during a crisis:

- Rotate staff members between high- and low-stress areas
- Provide breaks
- Offer a refresher area with food and water
- Monitor staff's ability to function
- Encourage continual self-assessment using personal evaluation tools like the one offered in Module 6
- Recognize that it may be difficult for staff members who have been "left behind" while others go out into the community to help
- Ensure that formal or informal debriefing services are available to all staff and know when to call on outsiders for debriefing

During a crisis, administrative staff also may be called upon to adopt roles that are outside their normal range of experience. Identify possible roles that administrative staff might play in advance and cross-train them in these areas. In addition, encourage administrative staff to review Module 8, which provides information for paraprofessionals.

Self-Care for Managers

Self-care is often difficult for managers. They are typically very good at taking care of others and at reminding others to take the time for self-care. But, with so many people depending on them during a crisis, it is often hard to take the time needed to prevent their own burn out. Module 6 identifies the best strategies for self-care during a crisis.

The best advice I could give is that self-care is critical, and that, as managers, we really have to take off that "we can be all things to all people" mentality when serving in a disaster. If you don't take care of yourself, you will burn out. It's almost a guarantee.

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Community Resilience Project

Managing the Immediate and Early Aftermath of a Terrorist Event

The table below provides a general description of some of the roles and responsibilities a manager typically assumes during the immediate and early aftermath of an event.

Table 7–2: Managerial Roles in the Immediate and Early Aftermath of a Terrorist Event[42]

Objective	Task
Coordinate response with other agencies.	• Convene with other mental health program managers, local and state response administrators, and national coordinators. • Determine an overall response strategy and the organization's role in it.
Gather information about the event and conduct a needs assessment.	• Determine the impact on survivors (e.g., number of fatalities, injured, homes and schools destroyed). • Determine the impact on high-risk groups (e.g., injured, relocated families, elderly, first responders). • Determine specialized skills requirements (e.g., language, children).
Allocate staff resources and coordinate mental health response.	• Assess staff members' strengths, limitations, and levels of training. Assess specialized skills. • Dispatch appropriate team members to the terrorist site. • Establish crisis lines or other systems to respond to requests for services and information.
Coordinate communication of information to the media and the public.	• Mobilize appropriate communication officers. • Activate emergency risk communication plan.
Coordinate with other response agencies to provide mental health services to first responders and monitor staff members.	• Provide debriefing and crisis intervention services. • Provide education services. • Monitor staff members for stress and vicarious traumatization.
Coordinate documentation of services.	• Conduct a response evaluation. • Document challenges and lessons learned in after-action reports. • Set up archives.

[42] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

Summary

This module provides managers of mental health staff and services with guidance on how to better equip themselves and their staff to provide services during the aftermath of a terrorist event. It suggests management practices and protocols to help facilitate a clear chain of command and open lines of communication among staff. It guides the manager through an assessment of staff's strengths and limitations to help identify and hire new employees, and to develop appropriate staffing plans during a crisis. It also identifies several other key areas to consider prior to an event, such as the importance of staff training, logistics, resource planning, and self-care, and it concludes with a general description of the roles and responsibilities that a manager typically assumes during the immediate and early aftermath of a terrorist event.

Additional Resources

DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs, http://www.ncptsd.org/publications/disaster/index.html.

MODULE 8: PREPARING THE PARAPROFESSIONAL FOR A DISASTER

This module is dedicated specifically to mental health paraprofessionals. A paraprofessional is defined as an individual who helps alleviate the pain and distress of groups and individuals affected by a crisis or disaster. Typically, paraprofessionals are members of the affected community. Paraprofessionals are trained to serve as crisis counselors but are usually not academically trained human service professionals (e.g., social workers, professional counselors, psychologists, psychiatrists).

Paraprofessionals play an important and unique role during a response to a terrorist event. Some of the strengths that paraprofessionals bring to a counseling team include:

- Passion about helping people in need
- Connections to the community and specific groups, which can be essential during outreach activities
- Awareness of community resources
- Flexibility in the types of services they can provide

These qualities are critical to an effective disaster mental health response to terrorism and complement the skills and abilities of other disaster mental health workers. This module focuses on providing paraprofessionals with what they need to know in order to help disaster victims while maintaining their own emotional and physical health. In addition to reviewing this module, paraprofessionals are encouraged to read modules 1, 2, 4, 5, and 6 for more in-depth information.

After completing this module, paraprofessionals will be able to:

- Understand their role and boundaries as paraprofessionals
- Identify reactions to terrorism
- Understand basic immediate interventions for victims of terrorism
- Communicate effectively with victims
- Understand the importance of continual training
- Practice self-care

Role of the Paraprofessional

What can a paraprofessional do during and after a terrorist event? A paraprofessional can provide a range of practical services, as well as basic psychological support. Paraprofessionals are generally called outreach workers and their focus is on the secondary and tertiary victims who need support, psychoeducation, and perhaps some human services, but are not prime candidates for immediate treatment. Some examples of what a paraprofessional can do include:

Paraprofessionals are very critical in terms of community response to disaster because what we need to give to folks in the weeks after a disaster is a sense of comfort. We need to provide them information with how they can cope. The information isn't only about coping but about understanding their own fears and doubts and "symptoms" that they might be having—hyper-vigilance, intrusive thoughts, sleep problems, etc. All those things are normal, and it doesn't take a psychotherapist with a masters or doctorate degree to help people understand that. It takes people that are interested in others—warm, caring kinds of individuals who are comfortable approaching and talking to folks that they don't presently know.

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Project Director, Fairfax County
Community Resilience Project

- Provide information and education on reactions to disasters, what survivors can expect to feel, what survivors can anticipate, and how survivors can set priorities and make plans to meet their immediate needs
- Conduct outreach in the community to determine the extent of the disaster and whether there are people or groups in the community that need assistance
- Practice supportive, or active, listening with survivors and their families
- Validate survivors' reactions and resilience stories, and affirm that their feelings are normal
- Connect survivors with their families
- Provide referrals to other social services, as appropriate
- Refer disaster survivors to other resources within the project and within the community

Because paraprofessionals are not trained clinicians, they cannot diagnose mental illness or provide medical services, psychological therapy, or clinical advice of any kind. Due to the range of reactions to a terrorist attack, it is critical that the paraprofessional refer the victim to a clinician for further evaluation or treatment when appropriate.

Paraprofessional and professional disaster mental health workers provide services out in the community and often become aware of needs that are beyond the range of services they offer. The disaster mental health worker should not:

- Provide case management services
- Advocate on behalf of the survivor

- Engage in fundraising for disaster survivors
- Provide childcare, transportation, or other personal services for survivors

Overview of Reactions to Terrorism

A terrorist attack affects individuals and communities in many ways. Obviously, those who lose loved ones during the attack are affected the most directly and severely. But it is important to realize how deep and wide the impact of a terrorist attack can be on a community and its members. Terrorist activities can affect the whole community in countless ways for months or years after the event. Although some may be affected only in the immediate aftermath of the event, others will experience reactions for a long time, particularly if they were directly involved in the event, lost loved ones, or did not express their feelings or reactions to the event. The impact can be physical, behavioral, emotional, and/or cognitive. See Module 3 for information on common reactions, as well as more problematic reactions that may require referral for extensive intervention and counseling.

Overview of Range of Interventions/Services

Immediately following a terrorist event, the primary objective of mental health interventions are to facilitate emotional stabilization. Many survivors feel highly vulnerable and fearful, so interventions must emphasize protection and safety, as well as promote a sense of security.

After the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, interventions should aim to alleviate distress and help with problem-solving and recovery.

The following sections briefly describe interventions and services commonly used during the immediate aftermath of a terrorist event. Some interventions are conducted exclusively by mental health professionals and they are described to provide the paraprofessional with a comprehensive sense of the range of interventions. In some cases, it is possible that a paraprofessional may observe some of these interventions or possibly even assist a mental health professional in some way.

More information on the role of professional mental health workers can be found in Module 3.

Mental Health Professional Services and Interventions

The following sections describe services and interventions that are conducted by mental health professionals. These include psychological first aid, crisis intervention, informational briefings, psychological debriefing, brief counseling interventions, support and therapy groups, mental health consultation, and support role during death notification.

Psychological First Aid

Rapid assessment is conducted at the scene by mental health professionals to identify survivors who are most psychologically distressed and in need of medical attention. Initially, triage decisions are based on observable behaviors, such as shaking, screaming, or complete

disorientation, but additional attention may be paid to older adults and others who may be vulnerable because of health conditions and physical or cognitive limitations. Emergency intervention involves three basic concepts: protect, direct, and connect.

- Survivors need to be **protected** from viewing traumatic stimuli from the event. In addition, they need to be protected from curious onlookers and the media.
- When disoriented or in shock, survivors need to be **directed** away from trauma scene and danger, and into a safe and protected environment. A brief human connection with a disaster mental health worker can help to orient and calm them.
- Disaster mental health workers assist survivors by **connecting** them with loved ones, as well as with needed information and resources.

Psychological support involves comforting the survivor, addressing immediate physical necessities, listening to and validating feelings and stories, and other immediate needs.

Crisis Intervention

While crisis intervention is somewhat similar to psychological first aid, it goes beyond the first stages of the disaster to:

- Assist survivors to regain some sense of control and mastery over their immediate situations
- Reestablish rational problem-solving abilities

An underlying assumption is that the survivor's distress and coping difficulties are due to the suddenness, horror, and catastrophic nature of the event. Crisis intervention typically involves five components:

- Promoting safety and security (e.g., finding the survivor a comfortable place to sit, giving the survivor something to drink)
- Exploring the person's experience with the disaster (e.g., offering to talk about what happened, providing reassurance if the person is too traumatized to talk)
- Identifying current priority needs, problems, and possible solutions
- Assessing functioning and coping skills (e.g., asking how he or she is doing, making referrals if needed)
- Providing reassurance, normalization, psychoeducation, and practical assistance

Informational Briefings

Survivors will seek information about the location and well-being of their loved ones, levels of threat and danger, procedural information, criminal investigation updates, etc. Disaster mental

health workers do not provide informational briefings, but they may consult officials about the need to do so and offer to be present during briefings to provide support as needed. Generally, senior managers on the disaster mental health staff are designated to work with officials. They may offer suggestions to officials about:

- Appropriate language/terminology
- Level of detail for sensitive information
- Approaches for addressing intense emotional reactions
- Language to use in conveying messages of compassion and condolence

For more on communicating during a crisis, see Module 5.

Psychological Debriefing

Psychological debriefing is a group intervention that has been used with a wide range of groups, including emergency responders, survivors, and community groups. It involves a series of stages that move participants from a cognitive view of the event, to discussion and expression of emotions and reactions, and then back to more cognitively focused learning about coping and problem solving. Debriefings can be set up for specific groups according to need. For example, a debriefing was done in Northern Virginia with military chaplains who were at the Pentagon on 9/11.

Mental health professionals lead debriefings, but paraprofessionals also may participate in a debriefing as peer counselors under the direction of an experienced facilitator.

Components of psychological debriefing consist of:

- The facilitator introducing the process and ground rules
- The participants describing the stories of their involvement with the event
- The participants describing their thoughts, feelings, and reactions during and since the event
- The facilitator validating and normalizing reactions and providing psychoeducation
- The facilitator wrapping up the session by addressing issues, distributing brochures on stress and coping, and discussing when and how to seek professional help

Brief Counseling Interventions

The therapeutic goals of brief counseling interventions involve the following:

- Stabilizing emotions and regulating distress
- Confronting and working with the realities associated with the event

- Expressing emotions during and since the event, including anger, anxiety, and fear
- Understanding and managing post-trauma symptoms and grief reactions
- Developing a sense of meaning regarding the trauma
- Coming to accept that the event and resulting losses are part of one's life story

Support and Therapy Groups

Support and therapy groups are provided by mental health professionals. Group treatment is especially appropriate for survivors of terrorist events because of the opportunity for social support through the validation and normalization of thoughts, emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others can be powerfully helpful. In addition, group reinforcement for using stress management and problem-solving techniques may promote courage and creativity. Sharing information about service and financial resources, as well as other types of assistance, is another important function of support groups.

Groups may be offered for parents, children, members of a particular neighborhood or particularly affected occupational group, such as the airline industry post-9/11, and for survivors who suffered a particular trauma or loss (e.g., bereaved parents).

Grief counseling is an important component of group services. The Community Resilience Project found some victims were not ready to participate in grief groups until months or even a year after the death of their loved one. Family members were instrumental in encouraging others to participant in grief groups.

It is recommended that groups be facilitated by an experienced mental health professional, ideally with a co-facilitator, and be time-limited with expectations defined at the outset.

Mental Health Consultation

Mental health professionals may be brought into decision-making and planning teams to advise leaders regarding mental health issues, such as mental health support and leave time for rescue and recovery workers, as well as rituals and memorials to honor the dead.

Support Role During Death Notification

Mental health professionals typically do not deliver information regarding deaths but may participate on teams who accompany the person responsible for this notification. Mental health professionals provide support to the family receiving the news and, at times, to those conducting the notifications. They can also provide information to those responsible for the notification on specific cultural or ethnic customs regarding the expression of grief and rituals surrounding death and burial.

Paraprofessional Services and Interventions

This section describes services and interventions that can be conducted by mental health paraprofessionals. These include community outreach and psychoeducation.

Community Outreach

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism, and is the major role of a paraprofessional. Disaster mental health workers need to consider the nature of the event and its impact, and develop a flexible plan for community outreach.

*Paraprofessionals provide a real important entrée into the communities. Many times paraprofessionals that come to work on these projects are folks who speak the language, are familiar with the culture, and actually come out of the communities in which we want to work. They also provide key contacts in terms of relationships. The most effective work we do is not **to** communities but **through** communities, which means we have to have relationships with the key stakeholders and the opinion leaders, the spiritual leaders, the civic foundation leaders…Paraprofessionals bring us those relationships.*

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors and family members through the media and the Internet, and maintaining 24-hour telephone hotlines that are staffed with people who speak the languages spoken in the communities being served (providing services via hotlines usually requires additional training)
- Participating in or conducting meetings for preexisting groups through churches, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers
- Planning activities that improve communication and understanding within communities and between cultural groups—such as cross-cultural dialogues, life skills workshops, and multicultural outreach teams

Community outreach requires:

- Ability to initiate conversations with those who have not requested services
- Good interpersonal skills
- Ability to quickly establish rapport, trust, and credibility
- Thinking on your feet

- A sense of diplomacy
- Knowledge and respect of values and practices of cultural groups impacted by the event

The outreach worker needs to coordinate with many other organizations and groups. Some examples of community groups that may be targeted by outreach efforts are:

- AA/NA meetings
- Childcare providers
- City Board meetings
- Community social and recreational events
- Elderly programs and residences
- Employment centers
- Employment fairs
- Ethnic markets and restaurants
- Food stamp office
- Grocery stores
- Health clinic
- Individual civic associations
- Interfaith groups
- Libraries
- Local mental health agency meetings
- Malls
- Meals on Wheels and Food and Friends
- Mental health group homes and residential communities
- Public housing
- Recovery homes
- Recreation centers
- Religious organizations

- Residential high-rises
- Schools
- Senior centers

The outreach worker needs to recognize that outreach takes different forms based on the target population and based on the context of time and setting. Creative activities are needed to reach the community. Examples of creative outreach initiatives enacted early in the response by the Community Resilience Project include:

Some of the salesmen turned out to be some of the best outreach workers because they were very comfortable with approaching people that they might not know and having a chat with them.

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Community Resilience Project

- Holding group sessions on coping with terrorism and stress management, offered in every possible community location
- Conducting workshops in the schools on anger management, diversity education and cross-cultural community building (e.g., elementary age students create a town called Xenophilia), listening skills, making friends, and emergency preparedness
- Holding weekly lunch time stress busters at middle and high schools
- Conducting stress management workshops for police department (facilitated by a critical incident stress debriefing-trained crisis counselor)
- Conducting outreach to hospital personnel
- Conducting cultural awareness programs
- Locating day-labor pick-up areas to provide outreach to underemployed and undocumented persons
- Establishing a weekly presence at a county employment center with outreach workers providing crisis counseling services to individuals while they use the resource room; one-time interactions and more ongoing relationships occur
- Partnering with the Virginia Employment Center: a relationship with this agency began while the Project and the VEC were both at National Airport. Services include crisis counseling and workshops on stress related to job loss post-9/11
- Attending the 9/11 Book Club at Barnes and Noble with books and discussions on topics of politics, peace, etc.
- Collaborating with the Virginia Cooperative Extension's program to design horticultural therapy events (for example, visits to healing gardens and tree planting)

- Conducting a Circle of Stories, a semi-structured group for individuals to tell stories of resilience; this can work well with senior adults, for whom reminiscence is enjoyable
- Conducting outreach to ESL classes and providing these students an opportunity to practice English and talk about their immigration experiences
- Collaborating with an in-home nursing care agency to provide one-on-one home visits to homebound seniors and their agency caregiver
- Stationing staff at WIC and immunization clinics to reach low-income young children and their parents
- Partnering with the 9/11 Black America Fund cash distribution (staff heard about this event on the radio and sought out the national organizers; cash vouchers were given out by the Fund, and Community Resilience Project staff were there to assist, distribute project information, and provide crisis counseling)
- Identifying and piggy-backing or participating in community events (fairs, festivals, Senior Law Day, multi-cultural events); piggy-backing on events, meetings, and pre-existing groups was beneficial in terms of attendance, ability for follow up, and, often, some degree of pre-existing group cohesiveness; the project also discovered that in some communities, creating a "conference-like venue" (having an expert speaker on some 9/11 related topic) seemed to alleviate some of the stigmas and fears related to mental health
- Co-locating at a health clinic and public housing office
- Having an ongoing presence (walking the streets) in Latino neighborhoods
- Reaching out to Muslim communities by bringing information to informal gatherings or at formal community events that are organized around other issues; participation in holidays
- Using ride-alongs with police and firefighters to build trust and to discuss 9/11 (intensive crisis counselors, CISM trained)
- Switching to a wellness approach in the winter months in response to community need
- Hiring dynamic, well-connected, and respected indigenous outreach workers
- Participating in a resilience expo involving multiple ethnic communities
- Using drama and music
- Ongoing stress busters—library and schools
- Visiting high school classrooms and collaborating with groups who serve teens
- Developing and distributing various brochures that target specific groups

Outreach activities must be responsive to the changing needs of the community. The outreach workers need to be ready to respond to community fears and new terrorist threats. Unlike a natural disaster, terrorism is an ongoing event. Heightened fears and hypervigilance are prevalent throughout the community. Additional terrorist-related incidents and alerts perpetuate fear and increase stress. For example, the sniper incidents in 2002 in Northern Virginia caused tremendous fear throughout the state. Community outreach was a key service during this period because the public was eager for support and information on how to cope. A new section of the Community Resilience Project Web site was developed called "Coping with the Sniper Attacks," and during the month of the attacks, there were more than 24,000 hits to the Web site. Outreach teams distributed the "Coping with Sniper Attacks" brochure at gas stations, strip malls, and other locations. Community members who received the brochure were thankful, and many shared their feelings and reactions with project staff.

Psychoeducation

Psychoeducation for survivors, their families, health care providers, and providers of community services is a core component of mental health response. Information that is typically provided covers these topics:

- Typical reactions, including "normal reactions to abnormal situations"
- Grief and bereavement
- Stress management
- Effective coping strategies
- When to seek professional help

Psychoeducation may be used informally in conversation, incorporated into group presentations and as written material for widespread distribution. There is a wealth of materials available through the Center for Mental Health Services and past crisis counseling projects. Materials should be oriented specifically to the actual event and locale, and adapted for each group or population so that it is appropriate for that group. Educational presentations for parents and teachers to help them recognize children's reactions and help them cope may be offered through schools, religious organizations, and other community events. When developing written materials, consider literacy levels and the need for multiple languages.

The Community Resilience Project distributed brochures (copies are available on http://www.dmhmrsas.state.va.us/organ/co/offices/commissioner/terrrorismcb.htm and http://www.samhsa.gov.) on the following psychoeducation topics:

- After a disaster self-care tips for dealing with stress
- Anger management
- Anger management in the workplace

- Checklist for potential reactions and coping strategies
- Checklist for recognizing potential reactions in children and strategies to help them cope
- Children and the fear of war and terrorism—tips for parents and teachers
- Coping in unsettling times—tips for students
- Coping with the holidays and other special days
- Coping with past and potential tragedies
- Coping with terror alerts
- Disaster counseling
- Helping children cope
- Helping children cope in unsettling times—tips for parents and teachers
- Helping children cope with crisis: care for caregivers
- How to deal with grief
- Mental health aspects of terrorism
- Psychological preparedness for stressful events
- Relaxation tips
- Self care tips for dealing with stress
- Sleep tips
- Stress in the workplace
- Stress management for senior citizens
- Stress management for parents and caregivers
- Stress management for teenagers
- Stress management tips

Communicating Effectively With Survivors

Disaster mental health workers' most important tool is communication, both verbal and nonverbal. There are several major goals for the communication that paraprofessionals have with survivors.

- **Gather information**—Ask questions to understand the basic facts of a person's current situation.
- **Help clarify meaning**—Ask open-ended questions to clarify the meaning of a person's statement.
- **Provide comfort**—Listen to survivors' stories to help them work through what has happened.
- **Assist in problem solving**—Help survivors develop solutions to the practical problems they encounter as a result of the terrorist event.

This section describes several communication techniques. It is important that paraprofessionals practice these communication techniques before working with survivors so that they come naturally. One way of practicing active listening and other communication techniques is through role-playing. The role of the paraprofessional is to provide support and assist in problem-solving—not provide psychotherapy. Using common language (not psychological jargon or bureaucratic terms) also will be very helpful in communicating with survivors.

Active Listening

The art of listening has three parts:

- Listening to and understanding nonverbal behavior
- Listening to and understanding verbal messages
- Listening to and understanding the person

Tips for employing good, active listening skills are below.

- **Paraphrase**—Rephrasing portions of what the survivor has said conveys understanding, interest, and empathy. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . ." or "I have heard you say that . . ."
- **Reflect feelings**—The paraprofessional may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared, etc.; does that fit for you?" This helps the survivor identify and articulate his or her emotions.

- **Allow expression of emotions**—Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. The paraprofessional helps by remaining relaxed and letting the survivor know that it is okay to feel that way.

- **Use nonverbal cues**—The paraprofessional can use facial expressions (e.g., smiling at appropriate times), eye contact, open body language, and head nodding to show survivors that he or she is listening and hears what they are saying.

- **Allow for silence, if appropriate**—Silence gives the survivor time to reflect and become aware of feelings and can prompt the survivor to elaborate. Some survivors will not feel like talking much. Simply "being with" the survivor can be supportive.

Some Do's And Do Not's

Do say:

- These are normal reactions to a disaster.
- It is understandable that you feel this way.
- You are not going crazy.
- It was not your fault; you did the best you could.
- Things may never be the same, but they will get better and you will feel better.

Do not say:

- It could have been worse.
- You can always get another pet/car/house.
- It is best if you just stay busy.
- I know just how you feel.
- You need to get on with your life.

The human desire to try to fix the survivor's painful situation or make the survivor feel better often underlies the preceding "Do not say" list. However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers validate the survivor's experiences, feelings, and perspectives. One way to help validate is to use the following leads to reflect what the survivor is expressing:

Empathetic Response Leads

- So you feel . . .
- I hear you saying . . .
- I sense that you are feeling . . .
- You appear . . .
- It seems to you . . .
- You place a high value on . . .

Helpful Phrases

- I am listening
- Tell me more about that
- Sounds like talking about that is hard for you
- Sometimes talking about it helps
- Sounds like you are angry about that
- You sound lonely, sad, frustrated . . .

Exploring the Problem

One way that the paraprofessional can be very helpful to the survivor of terrorism is by helping the person find solutions to practical problems. It is important to help the survivor recognize his or her own strengths so that he or she can successfully recover from the event.

Below are examples of open-ended questions that help explore problem-solving strategies.

- What ideas have you already considered?
- Can you tell me what you have already done about that situation?
- How did you handle similar situations in the past?
- What part of the problem is something you have control over?

Workers may consider the three factors below when providing practical information or referrals to survivors as they explore their problems.

- *Relevance*—Information must make sense to the person receiving it.
- *Relationship*—The message must be related to the person's need for information.
- *Responsibility*—The person is responsible to use or not use the information.

Guiding Principles for Cultural Competence

It is always important for paraprofessionals to be sensitive to the needs, experiences, practices, and communication styles of different groups and populations. But during terrorist events, the need for cultural competence is particularly heightened, as the impact of the event spreads throughout the community, affecting groups of people in unique ways.

Although race/ethnicity and age are two of the most common factors that people think about when considering cultural competence and the needs of special populations, there are additional considerations in the wake of a terrorist attack, including:[43]

- Refugee and immigrant status
- Gender
- Religion
- Physical disability status
- Mental health
- Income levels
- Profession/employment status
- Languages and dialects
- Education and literacy levels

Some overall concepts to consider about cultural competence are listed below.

- Understand that respect for the survivor and his or her experiences is critical in getting survivors to talk.
- Learn as much as possible about the demographics and psychographics of different groups.

[43] Athey, J. (2003). Developing cultural competence in disaster mental health programs: Guiding principles and recommendations. (DHHS Publication No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- Use a peaceful and soothing communication style.
- Watch for signs of confusion during discussions. Consider changing communication style to ease the survivor's anxiety.
- Use messages to communicate the value of the survivor's experiences and needs.
- Respect a survivor's unwillingness to talk about a particular subject.

When a terrorist event involves a particular community in some way (e.g., Muslims in relation to 9/11), certain special populations may experience backlash. This kind of backlash may retraumatize those populations and may make it difficult to communicate with them or make them feel uncomfortable about seeking help with respect to their emotions and other needs.

For more information on cultural competence and populations with unique needs, see Module 4.

Setting Boundaries

A paraprofessional's primary role is to provide emotional support and practical help. But during a terrorist event, the guidelines of what "help" encompasses can easily become blurred. It is very important that paraprofessionals assess their own personal and professional boundaries and come up with a concrete definition of how to assist survivors. Below are some things for paraprofessionals to consider.

Personal Boundaries

- Realize that some individuals have spatial concerns and are uncomfortable being touched by strangers. An individual could react negatively if a paraprofessional tries to pat his or her arm in sympathy or sit too close. Ask if it is okay to touch the individual or to sit or stand close to him or her.
- Maintain boundaries. Outreach is providing emotional support, information, and referrals. It is *not* playing chauffeur, housekeeper, or personal shopper. The paraprofessional needs to be careful to maintain boundaries with a survivor. Signs of crossed or blurred boundaries might include:
  - Inviting them to dinner
  - Socializing with them
  - Sending their children birthday cards
  - Speaking on the phone with them numerous times each day
  - Accepting gifts

- Recognize personal emotional triggers. Paraprofessionals should monitor these "hot points" and know how to manage them.

Professional Boundaries

- Be clear about the role of a paraprofessional and the importance of linking survivors to community resources and providing support.
- Be aware of confidentiality issues and follow team guidelines.
- Talk with survivors about their feelings without analyzing their reactions. Know how to identify more problematic reactions and when to refer for a more comprehensive assessment.

Self-Care

Self-care is critical. Before paraprofessionals can take care of others, they need to care for themselves by focusing on personal unique strengths in listening to survivors, giving survivors information about resources, and connecting survivors with needed assistance. Paraprofessionals need to understand that they:

- Will encounter situations over which they will have no control and problems they will not be able to solve
- Can still strive to provide the best possible services within the limitations of the situation at hand
- Can accept that as a job well done

The following are ways to maintain emotional and physical health:

- Limiting the amount of time spent watching television coverage of the terrorist event
- Staying physically healthy—exercising, eating right, and getting rest
- Sticking to routines as much as possible

Stress at the event site can be relieved by:

- Taking breaks or going for walks
- Rotating shifts with coworkers
- Talking with a supervisor or other team members about the challenges of disaster counseling

The importance of regular communication with one's clinical supervisor can not be over-emphasized. A supervisor's guidance can provide clear direction about establishing and maintaining boundaries, as well as stress reduction and other issues related to self-care.

Module 6 offers more extensive information on self-care, including a *Self-Monitoring Checklist* and a list of suggestions for how reduce stress and restore energy.

Continual Training

It is important to participate in ongoing training. Staying current about available resources and how to access them will help accomplish the job of connecting survivors to the assistance they need. With ongoing training in reactions to terrorism and response skills, paraprofessionals will be better prepared to assess situations and refer victims, when appropriate. Role-play exercises, in particular, let paraprofessionals practice different types of listening and how to give out information. See next page for a sample role-play exercise.

Some mental health background would be helpful, but I think it's more…how to engage people, how to talk to people—any training around that would be very, very important. I think they also need to know how they really need to be available and how it is an important job that they're really doing as well. Sometimes I think it's hard for them to realize we really do make an impact on people.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

Table 8. Communication Techniques for Paraprofessionals' Role-Play Exercise

Scene of the Disaster:

A sniper has shot a woman at a shopping center. FBI and other law enforcement officials close off the shopping center for 24 hours to conduct their investigation. The shopping center has just reopened and employees are returning to work for the first time since the incident.

The Action:

The paraprofessional approaches the manager and several employees of one of the stores within the shopping center. The manager and employees are visibly upset.

Enlist the help of an associate, preferably an experienced mental health professional, to enact the scene. Assume the role of the mental health paraprofessional who has just arrived on scene to provide outreach to the shopping center employees. Practice structured support conversation about the terrorism experience and provide education about disaster stress.

Techniques for Handling the Situation:

Active Listening

It is best when workers validate victim's experiences, feelings, and perspectives. One way to help validate is to use the following leads to reflect what the victim is expressing:

Empathetic Response Leads

- So you feel…
- I hear you saying…
- I sense that you are feeling…
- You appear…
- It seems to you…
- You place a high value on…

Helpful Phrases

- I'm listening
- Tell me more about that
- Sounds like talking about that is hard for you
- Sometimes talking about it helps
- Sounds like you are angry about that
- You sound lonely, sad, frustrated…

Summary

This module provides paraprofessionals with an introduction on how to work with survivors of an act of terrorism. A number of tools are provided to help paraprofessionals understand typical reactions to a terrorist attack and how to communicate with survivors from all cultures to help them solve the practical problems that they will encounter on the road to recovery. In addition, because working with survivors can be very demanding, this module outlines several ways—setting boundaries, self-care, training—that paraprofessionals can use to help themselves prepare for disaster work and stay psychologically and physically health during and after the event so that they can do their jobs effectively.

APPENDIX A: WEAPONS OF MASS DESTRUCTION

Weapons of Mass Destruction 101[44, 45]

The acronym commonly used to describe all of the varieties of weapons of mass destruction is CBRNE, which stands for Chemical, Biological, Radiological, Nuclear, and Explosive. It is important to note that an attack may fall into more than one category (e.g., a bomb laced with chemicals).

Chemical

Chemical weapons are toxic agents that can be gases, liquids, or solids and may cause injury or death. A chemical attack would result in the rapid onset of symptoms in the people exposed, such as nerve paralysis, choking, or skin blistering, depending on the specific toxin used. The severity of one's reaction is determined by the type of agent, the amount of the agent that is used in the attack, and the duration of exposure.

A chemical agent would most likely be disseminated as an aerosol or gas. It is difficult to disperse a chemical agent into the open air in a concentration that would cause damage because agents often dissipate rapidly and are heavily influenced by weather conditions, such as temperature, and wind speed and direction.

If a chemical agent attack were to occur, authorities would instruct residents either to seek shelter where they are and seal the premises, or to evacuate immediately. There is little assistance that the untrained can offer to the victims of chemical agents, particularly without full respiratory and skin protection.

Two examples of chemical agents that terrorists might use are sarin and mustard gas. Sarin is a colorless, odorless, and tasteless nerve agent compound that can appear in liquid or gas forms. Vaporized sarin, which is the most common form, affects the eyes and the respiratory system. Although antidotes are available, sarin is so lethal that even a small amount can cause death within a few minutes.

Mustard gas was used during World Wars I and II. It has a pungent odor and burns bodily tissues. It can cause skin, eye, and lung problems, which may not appear until several hours after exposure. Being exposed to a large amount or for a prolonged period of time could be life-threatening.

[44] Public health emergency preparedness and response, accessed at the Centers for Disease Control and Prevention Web site, http://www.bt.cdc.gov/

[45] Personal preparedness guide, accessed at the *Washington Post* Web site, http://www.washingtonpost.com/wp-dyn/health/ (Note: This site provides a great deal of Washington, DC-area specific information, including the bioterrorism sites for local jurisdictions.)

Biological

Biological warfare involves using bacteria, viruses, or toxins to cause potentially deadly diseases. It can be difficult to use these agents as weapons because many can survive only at certain temperatures or they are hard to create or disperse effectively. Depending on the type, the agent may be aerosolized or made into a powder and distributed through the air or in food or water. For those agents that are transmittable from person to person, terrorists may infect even themselves to purposely infect others.

Biological attacks are different than the other types of attacks described in this section because they may go undetected for days or even weeks. The detection of the event may occur only when people start showing signs of a disease. Once health officials realize that an attack has occurred, people may be asked to get a vaccination, seek treatment, or take steps to prevent infection (e.g., evacuate, shelter-in-place, use masks, wash hands).

Some of the diseases commonly discussed as potential "bioweapons" include anthrax, smallpox, botulism, plague, and tularemia. In the past several years, anthrax and smallpox have been in the forefront in the media. Therefore, this primer provides additional information on botulism and plague.

Botulism is a muscle-paralyzing disease caused by a nerve toxin produced by a bacterium, *Clostridium botulinum*, found naturally in soil. Typically, people who get botulism do so accidentally from food that has been improperly canned, stored, or prepared. However, the bacterium is fairly easy to produce, transport, and use, and it is highly poisonous, which makes it a possible weapon. The toxin may cause a number of neurological symptoms, including blurred or double vision, drooping eyelids, slurred speech, difficulty swallowing, and muscle weakness. These symptoms can occur hours, days, or even up to two weeks after exposure. The symptoms may progress to respiratory failure, paralysis, or death. An antitoxin is available and effective if administered quickly, but recovery can still take many weeks of intensive care.

Plague is an infectious disease that most people associate with the Middle Ages. There are several types of plague. Bubonic plague, the most common form of plague, occurs when an infected flea bites a person. The person develops swollen, tender lymph glands (called buboes), fever, headache, chills, and weakness. Bubonic plague does not spread from person to person. A biological attack would most likely occur through aerosolization of the bacteria. Breathing in these bacteria would cause pneumonic plague, which also can be spread from person to person through the air. With pneumonic plague, the first signs of illness are fever, headache, weakness, and rapidly developing pneumonia with shortness of breath, chest pain, cough, and sometimes bloody or watery sputum. The pneumonia progresses for two to four days and may cause respiratory failure and shock. Without early treatment, infected persons may die.

To reduce the chance of death from plague, antibiotics must be given within 24 hours of first symptoms. Antibiotic treatment for seven days will also protect people who have had direct, close contact with infected persons. Wearing a close-fitting surgical mask also protects against infection.

Radiological and Nuclear

Although the detonation of a nuclear bomb is a potential terrorism scenario, terrorists are more likely to use what is called a "dirty bomb," which is a traditional explosive device laced with radioactive material. This is easier to create (materials can be found in industrial areas worldwide), transport, and detonate, than a nuclear weapon. Although radioactive material would be scattered in a small area, most casualties would be due to the explosion, not the radioactivity. The radioactivity probably would be a low dose that might have some health effects on those directly exposed but probably would not kill anyone. It would, however, cause fear, financial hardship, and disruption in the affected area.

A nuclear bomb would cause widespread death and destruction, but it is much less likely to be used, due to the difficulty in acquiring and setting off such a weapon. If advance notice is given, evacuation is the clear choice, but if there is no time to evacuate, the best idea is to shelter-in-place. The three protective elements of a fallout shelter are shielding, distance, and time. Shielding refers to having heavy, dense materials (e.g., concrete) between a potential victim and the fallout particles, and distance refers to having as much distance between the person and the fallout particles as possible (e.g., being in a basement or the center of a large building). Time refers to the fact that radiation disperses fairly quickly, but one may need to stay inside the fallout shelter for days or weeks, depending on the situation.

The extent of radiation contamination depends on a number of factors, including the size of the explosive, the amount and type of radioactive material used, and weather conditions. The symptoms of radiation sickness are widespread and include nausea and vomiting; diarrhea; skin burns and inflammation; weakness; hair loss; and a number of other symptoms. Moderate-to-severe exposures may cause death in a few days to a few weeks if untreated, but health problems due to lesser exposures may take weeks or years to occur. Blood transfusions and bone marrow transplants are possible treatments.

An attack on a nuclear power plant would cause localized problems, but the problems would not be as widespread as those from a nuclear bomb. It could, however, cause radiation sickness and, later, cancers in a local area. Potassium iodine may help to reduce the risk of thyroid cancer in those exposed to certain kinds of radiation, but it will not protect people from all of the effects of such an attack.

Explosive

An explosive event refers to a bomb or other explosion not connected to radiological or nuclear materials. As was the case on 9/11, a massive explosion can cause widespread death and destruction, but an explosion can also be a small, more contained event.

APPENDIX B: PRESS RELEASES

Sample Press Release

Media Contact: (Name/Phone Number)

For Immediate Release

How to Talk to Children about _____

LOCATION—Experts encourage parents and teachers to talk to children about their feelings about _____. To help parents and teachers, the NAME OF ORGANIZATION offers the tips below.

- ❑ Provide children with opportunities to talk about what they are seeing on television and to ask questions.
- ❑ Do not be afraid to admit that you can't answer all their questions.
- ❑ Answer questions at a level the child can understand.
- ❑ Provide ongoing opportunities for children to talk. They will probably have more questions as time goes on.
- ❑ Use this as an opportunity to establish a family emergency plan. Feeling that there is something you can do may be very comforting to both children and adults.
- ❑ Allow children to discuss other fears and concerns about unrelated issues. This is a good opportunity to explore these issues also.
- ❑ Monitor children's television watching. Some parents may wish to limit their child's exposure to graphic or troubling scenes. To the extent possible, watch reports of the disaster with children. It is at these times that questions might arise.

-more-

How to Talk to Children about _____, page 2

- ❑ Help children understand that there are no bad emotions and that a wide range of reactions is normal. Encourage children to express their feelings to adults (including teachers and parents) who can help them understand their sometimes strong and troubling emotions.

- ❑ Try not to focus on blame.

- ❑ In addition to the tragic things they see, help children identify good things, such as heroic actions, families who are grateful for being reunited, and the assistance offered by people throughout the country and the world.

Teachers also can help children through art and play activities, as well as by encouraging group discussions in the classroom and informational presentations about the disaster.

If you or someone you love needs help with their reactions to _____, call the NAME OF ORGANIZATION at NUMBER or visit WEB ADDRESS.

###

Sample Press Release

Media Contact: (Name/Phone Number)

For Immediate Release

Recognizing and Dealing with Reactions to _____

LOCATION—The recent _____in our area have caused many of us to have reactions that include anxiety, fear, anger, and hyperviligance. While these reactions are to be expected, the NAME OF ORGANIZATION offers the following information about typical reactions and ways to cope.

What Are Typical Reactions to a Traumatic Event or Disaster?

- ❑ Fears and anxieties
- ❑ Reluctance to leave home
- ❑ Hyperviligance, excessive watchfulness, being on-guard for possible threats
- ❑ Irritability
- ❑ Fatigue or exhaustion
- ❑ Anger
- ❑ Confusion
- ❑ Changes in appetite
- ❑ Changes in sleeping patterns; problems going to sleep, nightmares
- ❑ Sensitivity to loud noises
- ❑ Alcohol and other drug use
- ❑ Sadness, crying
- ❑ Inability to concentrate

What You Can Do To Help

When helping family, friends and co-workers, individuals often benefit from talking about the experience. Some tips "Do's and Do nots" for listening are:

Do say:

- These are normal reactions to an abnormal situation.
- It is understandable that you feel this way.
- You are not going crazy.

-more-

Recognizing and Dealing with Reactions to _____, page 2

- It wasn't your fault, you did the best you could.
- Things may never be the same, but they will get better, and you will feel better.

Do not say:

- It could have been worse.
- It's best if you just stay busy.
- I know just how you feel.
- You need to get on with your life.

For children, reassurance is the key. Very young children need a lot of cuddling, as well as verbal support. Answer questions about the situation honestly but do not dwell on frightening details or allow the subject to dominate family or classroom time indefinitely. Encourage children of all ages to express emotions through conversation, drawing, or painting but allow silences. Listen attentively to what children are saying and provide reassurance without minimizing their fears.

Additionally, try to maintain a normal household and encourage children to participate in recreational activity and limit viewing of news coverage and when you view news coverage do it together so you can answer questions and provide support. Adults should try to resume regular social and recreational activities when appropriate.

Finally, acknowledge that you may have reactions associated with the traumatic event, and take steps to promote your own physical and emotional healing.

If you or someone you love needs help with their reactions to _____, call the NAME OF ORGANIZATION at NUMBER or visit WEB ADDRESS.

###

Sample Press Release

Media Contact: (Name/Phone Number)

For Immediate Release

New Web site Provides Information About Reactions to 9/11 and Services Available in Northern Virginia

Northern Virginia—The Community Resilience Project of Northern Virginia announced today that their Web site, http://www.communityresilience.org, is now available to provide information about the emotional and physical reactions to the anniversary of the September 11, 2001 terrorist attacks and the free help that is available to people who live or work in northern Virginia.

Hosted by the Community Resilience Project, the Web site has special sections targeting children, teenagers, adults, seniors, teachers, mental health practitioners, and more. Information about the specific services that are available in the four areas that make up the Community Resilience Project, which are Arlington, Alexandria, Fairfax, and Loudoun, is also available.

"The new Community Resilience Project Web site will be a valuable tool in helping people understand what they, their spouses, their children, and others are going through, especially as we approach the anniversary of the attacks," said WHO, TITLE of ORGANIZATION. "It is important not only to recognize these reactions, but also to know how to handle them effectively. The Web site gives people access to a wealth of important information that can help them and their loved ones through this difficult time."

Insert quote from an official spokesperson providing reassurance.

" _____

_____

_____ "

-more-

Community Resilience Project Web site Announced, page 2

List contact information, ways to get more information, and other resources.

_____

_____

_____

The Community Resilience Project of Northern Virginia, funded through the Federal Emergency Management Agency (FEMA), is a cooperative venture among the counties of Arlington, Fairfax, and Loudoun, and the city of Alexandria. The free services available through the Community Resilience Project include individual and group counseling, support groups, stress management, emergency preparedness, dealing with grief and loss, children and trauma, county services referrals, and financial or economic guidance. Services are also available to the hearing impaired. To find out more, call 1-866-400-2951 (TTY: 703-228-4831) or visit http://www.communityresilience.com.

###

Template for Press Statement[46]

If the media are "at your door" and you need time to assemble the facts for this initial press release statement, use " Template for Prescripted, Immediate Response to Media Inquires". Getting the facts is a priority. It is important that your organization not give in to pressure to confirm or release information before you have confirmation from your scientists, emergency operations center, etc.

The purpose of this initial press statement is to answer the basic questions: who, what, where, when. This statement should also provide whatever guidance is possible at this point, express the association and administration's concern, and detail how further information will be disseminated. If possible, the statement should give phone numbers or contacts for more information or assistance. Please remember that this template is meant only to provide you with guidance. One template will not work for every situation.

FOR IMMEDIATE RELEASE

CONTACT: (name of contact)

PHONE: (number of contact)

Date of release: (date)

Headline—Insert your primary message to the public

Dateline (your location)—Two-three sentences describing current situation

_____

_____

_____

Insert quote from an official spokesperson demonstrating leadership and concern for victims.

" _____

_____

_____ "

Insert actions being taken.

_____

_____

_____

[46] Centers for Disease Control and Prevention. (2003). Emergency risk communication (ERC) CDCynergy. Office of Communications, U.S. Department of Health and Human Services.

List actions that will be taken.

_____

_____

_____

List information on possible reactions of public and ways citizens can help.

_____

_____

_____